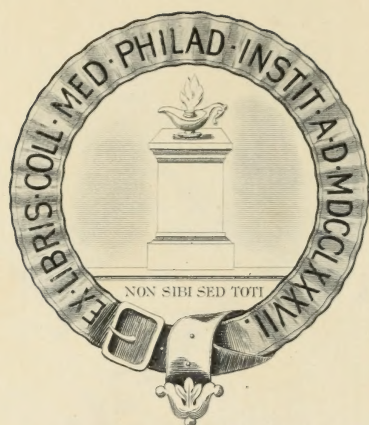






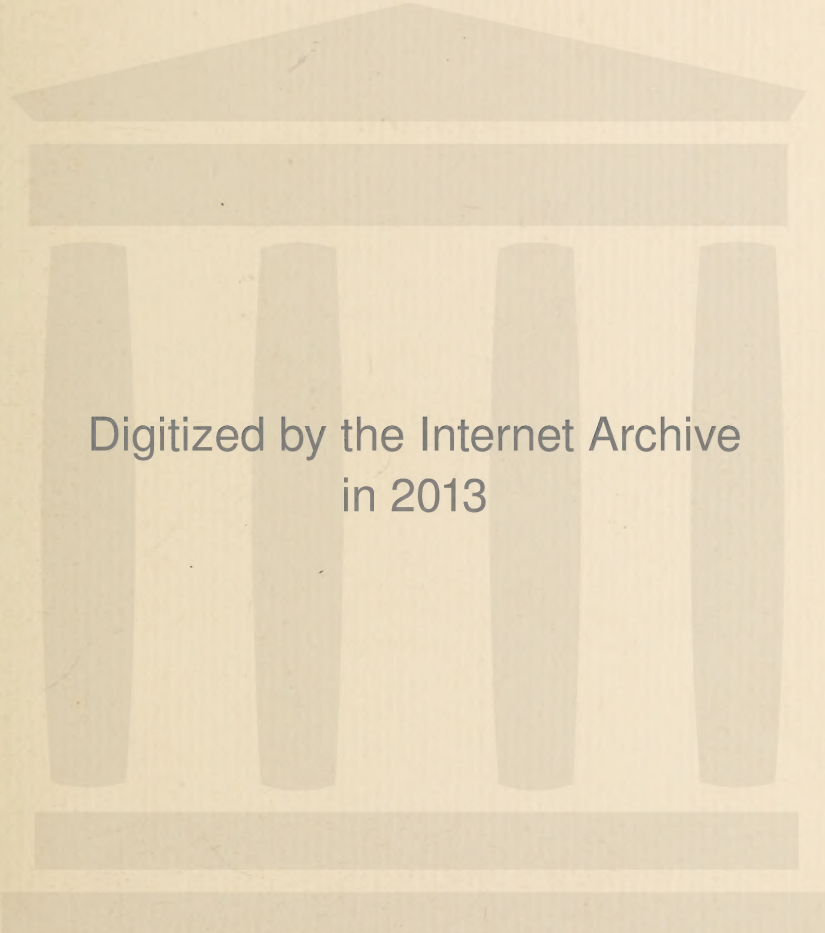
15853



Class \_\_\_\_\_ No \_\_\_\_\_

Presented by  
*R. J. Douglass, M.D.*

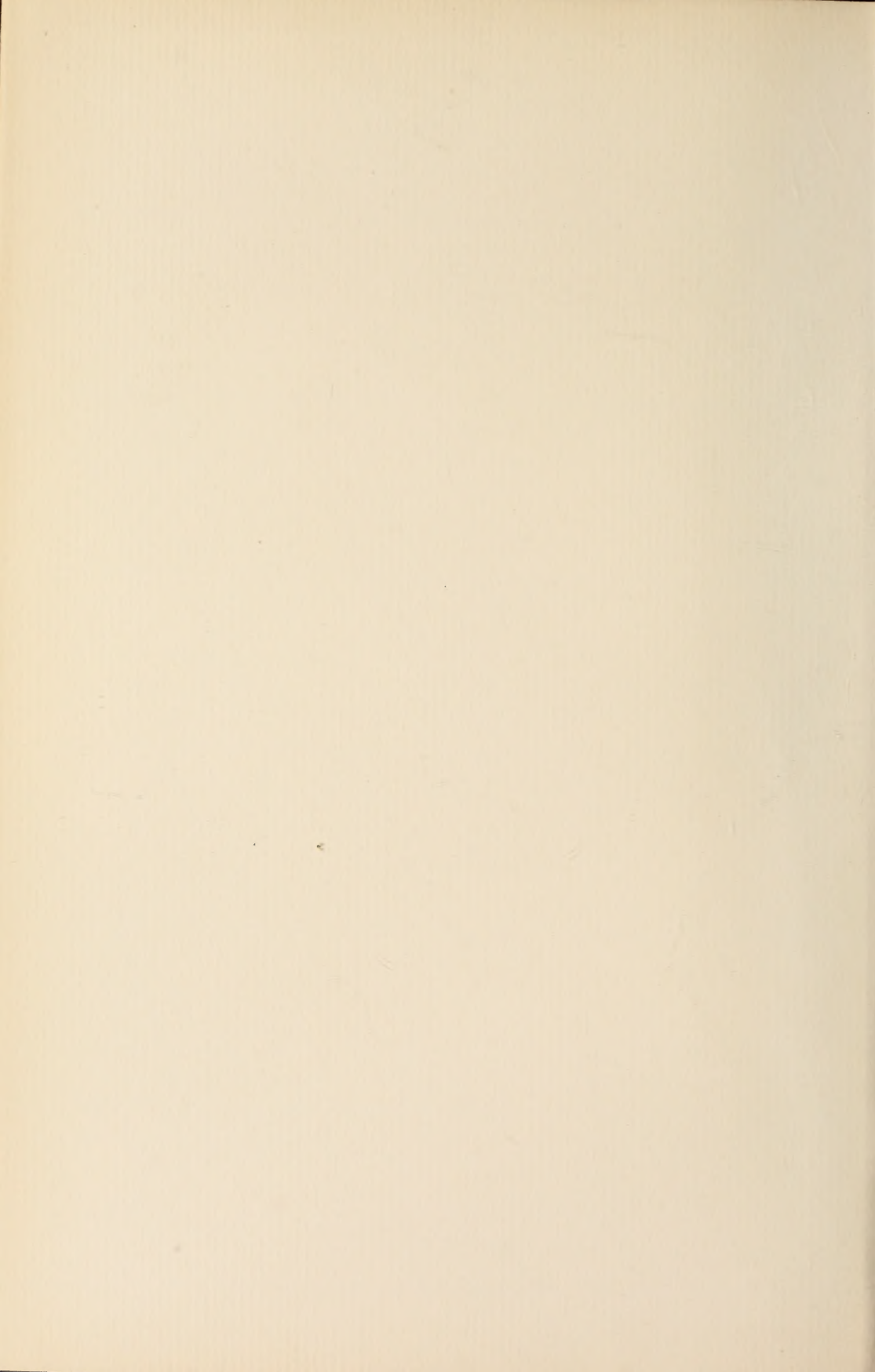




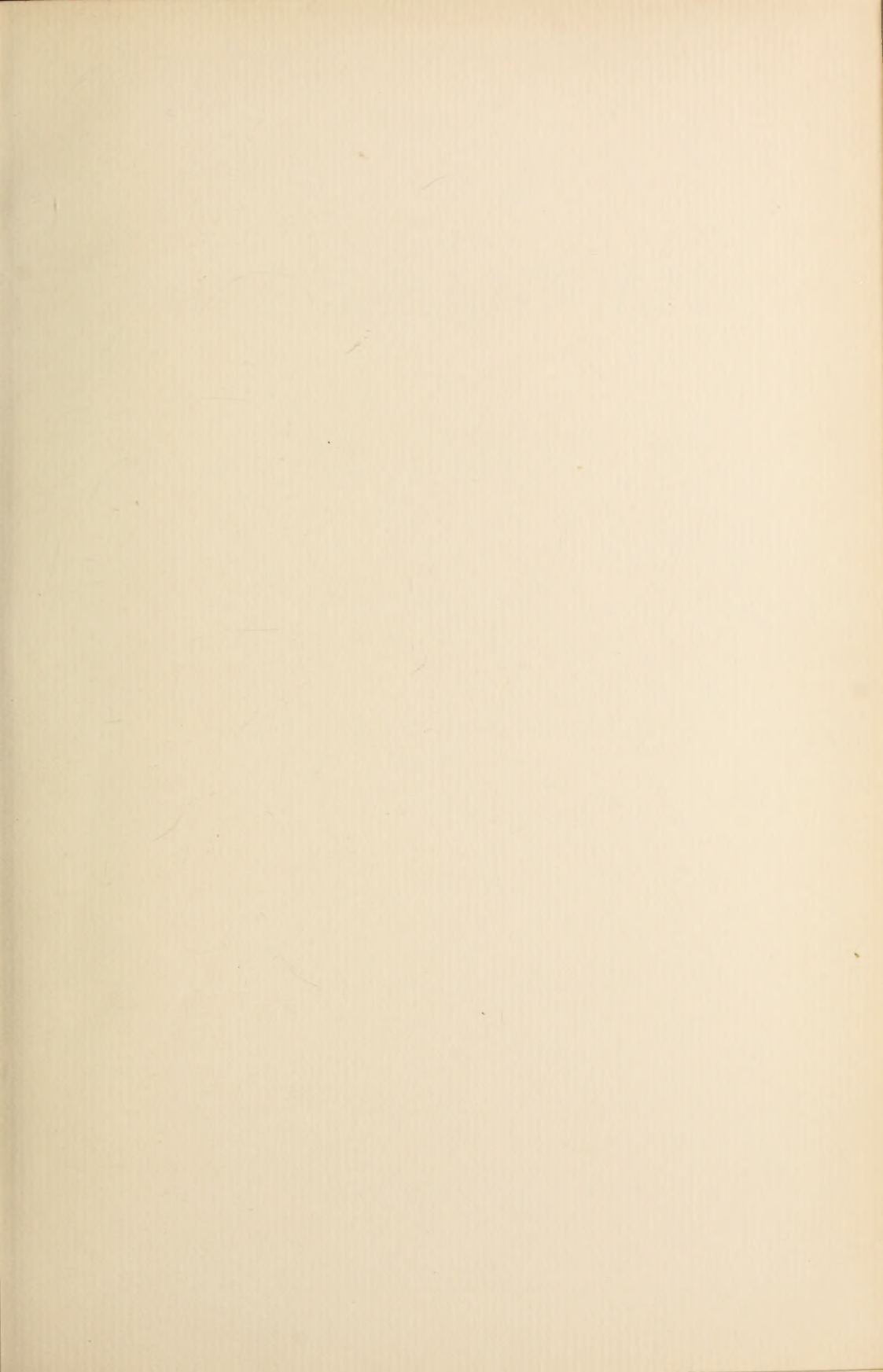
Digitized by the Internet Archive  
in 2013

<http://archive.org/details/hahnemannian33homo>

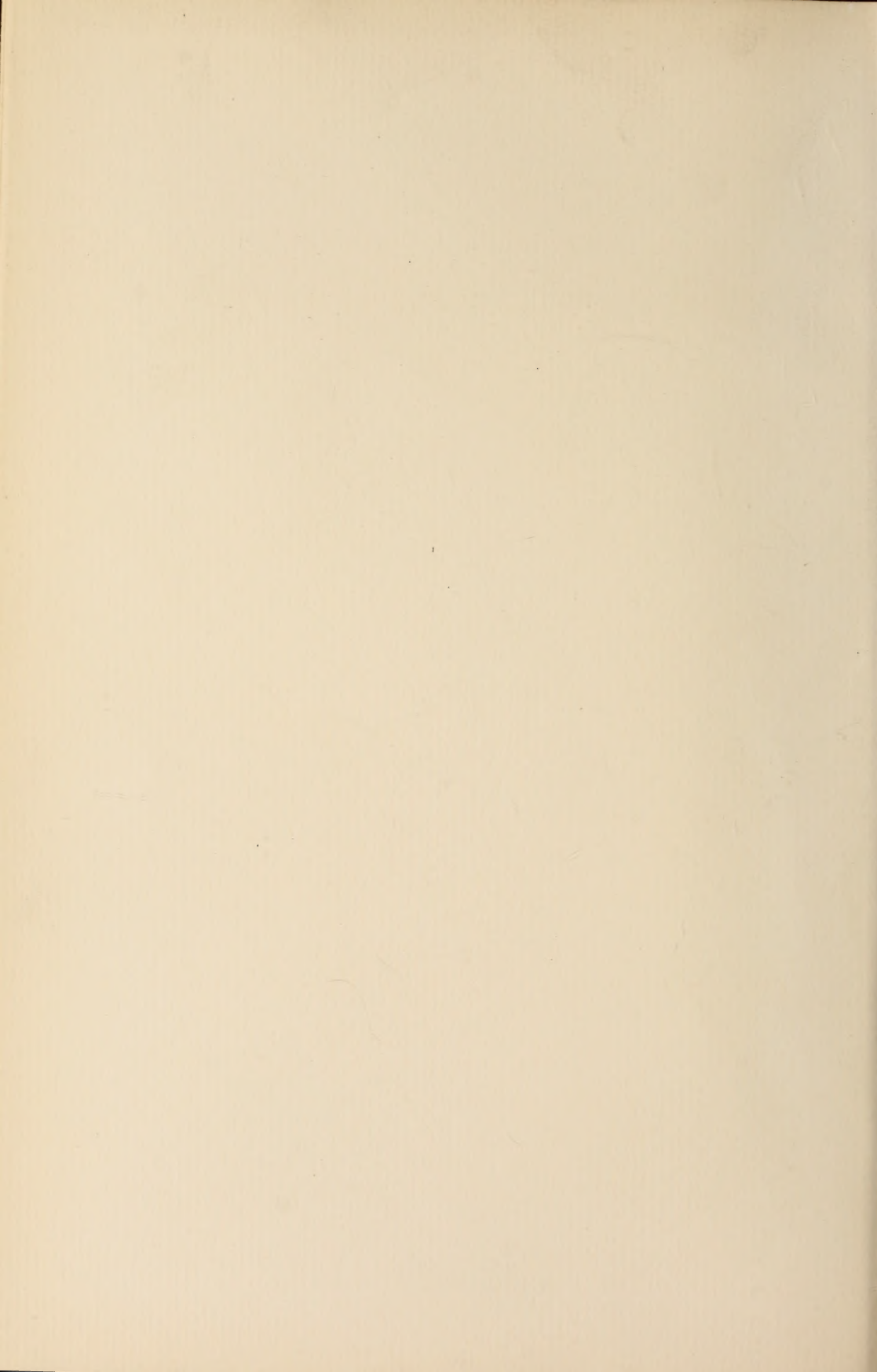














87

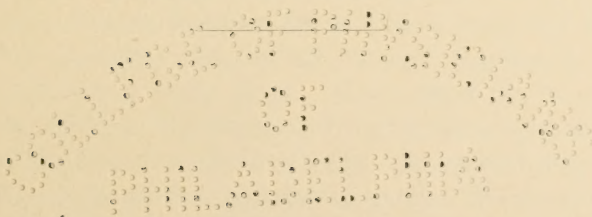
# The HAHNEMANNIAN Monthly.

(VOLUME THIRTY-THIRD.)

JANUARY TO DECEMBER,  
1898.

---

EDITED BY  
WM. W. VAN BAUN, M.D.

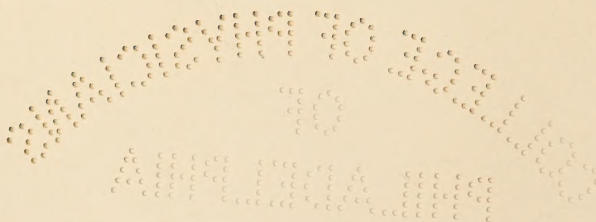


PHILADELPHIA :

1898.

**APR 25 1899**

COPYRIGHT, 1898.



APR 23 1898



# THE HAHNEMANNIAN MONTHLY.

---

JANUARY, 1898.

---

## THE BAD NAUHEIM TREATMENT OF HEART DISEASE.

BY EDWARD R. SNADER, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Scranton, 1897.)

THE medical journals of late have contained paragraphs and articles respecting the Bad Nauheim treatment of cardiac disease, some of them more or less explicit as to the method employed, and some commenting upon the mode pursued there in a manner implying suspicion of the results alleged to have been obtained, and still others so vigorously impaling the theories of the action of baths and movements used in the Bad Nauheim cure, that I was quite naturally in the dark as to the real status of the subject. The experiments with the methods conducted in this country have been, so far as I have been able to ascertain, rather meagre, and, withal, rather disjointed. Some tried manufactured baths alone. Some used the movements exclusively. Others still disputed the main assertions of the advocates of the Schott method of cure. Interested deeply, as I necessarily am, in all that pertains to cardiac therapeutics, and being "hazed" by the lack of unanimity of opinion concerning the treatment pursued, growing out of an imperfect understanding of the method and a too great willingness to discount

apparently proved assertions, I presume, I determined upon a personal inspection of Bad Nauheim and its remedial measures. I determined to be on the battle-ground, and in the thick of the fight. I shall in this paper endeavor to present some of the facts necessary to be known to the "American jury" before they arrive at a verdict.

#### REMEDIAL RESOURCES.

##### *Baths.*

The waters arising from two springs are employed as baths, viz.:

1. "The Great Sprudel" (Spring No. 7), containing, briefly, among other ingredients, chloride of sodium, 3.03 per cent., and carbonic acid gas, 0.392 per cent., at the natural temperature of 32° Cent. (89.6° F.)

2. Spring No. 12, "Friedrich Wilhelm-Quelle," is the second bath, containing chloride of sodium, 3.55 per cent., and carbonic acid gas, 0.361 per cent., with a temperature of 33° Cent. (91.4° F.)

3. Simple saline baths. The ordinary brine bath is one from which the carbonic acid has been removed, this result being produced by exposure to the atmosphere and by the removal of a certain amount of salts. These baths can be regulated as to the amount of saline and other solid material by the addition of a more or less uncrystallizable extract obtained from the original springs by evaporation and concentration by boiling. This substance is known as *mutterlauge* (mother-lye), and is very rich in chloride of calcium and bromine. This mother-lye is used most extensively to gradually and systematically (as is demanded by individual cases) strengthen other baths, more particularly the thermal brine baths, or weakened by the addition of common water. The temperature, of course, can be regulated at will.

Following is an analysis of the Nauheim mineral waters:

The waters contain many ingredients, but the most important are considered to be the *chloride of sodium*, THE CHLORIDE OF LIME, and, above all, the CARBONIC ACID GAS. These three elements, according to Schott, the originator of the present, or rather the most approved, method of application to



CONSTITUENTS.  The amounts of solids are given in grammes, as contained in 1000 grammes of water.	ANALYSIS.			
	Bathing Waters.		Drinking Waters.	
	Spring No.12.	Spring No. 7.	Kur-brunnen.	Karls-brunnen.
Chloride of sodium.....	29.2940	21.3245	15.4215	9.8600
Chloride of lithium.....	0.0536	0.0492	0.0267	Trace
Chloride of potassium.....	1.1194	0.4974	0.5270	0.0731
Chloride of ammonium.....	0.0712	0.0550	0.0371	0.0113
Chloride of calcium.....	2.3249	1.7000	1.0349	1.0578
Chloride of magnesium.....	0.5255	0.4402	0.7387	0.2040
Bromide of magnesium.....	0.0083	0.0060	0.0063	0.0014
Iodide of magnesium.....	Trace	.....	.....	.....
Sulphate of calcium.....	0.0352	0.0847	0.0238	0.2277
Sulphate of strontium.....	0.0499	0.0390	0.0324	0.0087
Bicarbonate of potassium.....	2.6012	2.3541	1.1461	0.9515
Bicarbonate of iron.....	0.0484	0.0392	0.0262	0.0152
Bicarbonate of manganese.....	0.0069	0.0065	0.0082	Trace
Bicarbonate of zinc.....	0.0089	0.0104	0.0070	Trace
Silicic acid.....	0.0213	0.0325	0.0186	0.0087
Arsenate of iron.....	0.0002	0.00086	0.00016	Trace
Phosphate of iron.....	0.0007	0.00046	0.00034	0.0002
Organic substances.....	Trace	Trace	Trace	Trace
Amount of solid constituents.....	36.1696	28.0886	19.0549	12.4272
Specific gravity.....	1.02757	1.62088	1.01475	1.0089
True carbonic acid gas.....	*2.7900	‡3.1107	1.9622	14.272
Temperature (Celsius).....	†35.3	‡31.6	21.4	15.

\* = 1456.1 ccm.

‡ = 1592.3 ccm.

† = 95.54 Fahrenheit.

‡ = 88.88 Fahrenheit.

the amelioration of cardiac disorders, are the active ones in producing the favorable issues secured at Bad Nauheim. The closest possible discrimination in the manner of administration of the baths is practiced. The time, the temperature, the strength, the period over which the baths shall be continued or interrupted, are all matters of profoundest attention on the part of the attending physician. Whether the bath shall be a simple saline, a thermal brine, an effervescent (sprudel-bad), or a current thermal brine or current effervescent (thermal strom and sprudel strom), are considerations that demand the utmost discrimination. Combinations of the waters from the two springs, Nos. 7 and 12, in varying proportions, are made, and for manifest reasons.

#### *Method of Administering the Baths.*

Except the plain water or simple saline ablutions, no baths

are given without a physician's prescription. Prescription blanks for baths contain the day, the month, the number of the spring or springs from which the water is to be employed for bathing, stating whether with or without carbonic acid gas, whether with or without or the amount of *mutterlauge* (mother-lye, a concentrated residue of the main salts contained in the *Grosser Sprudel* and *Friedrich Wilhelm-Quelle*, secured by evaporation, atmospheric exposure and boiling, and used to increase the power of the baths), the temperature of the bath, and the number of minutes the patient is to remain in the bath, and also remarks to the bath attendant.

All the "cardiacs" are carefully differentiated as to the kind and quality of baths at the commencement of treatment. The patients are examined sometimes twice a day, occasionally before, during and after the bath, generally, however, every two or three days, and their progress noted, great attention being paid to physical signs, and the baths altered as to strength, temperature, duration, or stopped temporarily, or the "cure" interrupted for two or three weeks, as may seem wise to the attending physician.

Following is a bath prescription in a case of simple dilatation of the heart, due to overstrain by too much climbing (the *Oertel* treatment), in a stout, gouty male of 45 :

Day,	Month.	Spring No.	Carbonic Acid.	Mother-lye.	Temperature. (Cent.)	Minutes.
30	July.	Thermal 7	With	None.	32½°	8
31	"	" 7	"	"	"	9
1	August.	" 7	"	"	"	10
2	Pause in the baths.					
3	August.	Thermal 7	"	1 litre.	32°	12
4	"	" 7	"	1 "	"	13
5	"	" 7	"	1 "	"	14
6	Pause.					
7	August.	" 7	"	2 litres.	31½°	15
8	"	" 7	"	2 "	"	16
9	"	" 7	"	2 "	"	17
10	Pause.					
11	August.	<i>Sprudel</i> 7	"	None.	Natural	8
12	"	" 7	"	"	"	9
13	"	" 7	"	"	"	10
14	Pause.					
15	August.	" 7	"	"	"	12
16	"	" 7	"	"	"	14
17	"	" 7	"	"	"	15

This is not a complete bath record, *i.e.*, it does not correspond



to what the patient would have received throughout the treatment. It is the beginning, simply. The patient was summoned home before he could complete the course of baths.

A course of baths is usually of six weeks' duration. Some patients with progressive lesions return annually; others secure enough benefit to last them for a year or two, or are even permanently benefited. The official season is from the 1st of May to the 1st of September.

The effects of the baths are to produce a slight sensation of chilliness, followed in a moment by an agreeable sensation of warmth. The respirations are at first deepened, and a sensation of præcordial, pulmonary or epigastric oppression is observed. These oppressive sensations are usually temporary. The bather comes out of his tub with a cutaneous covering of rosy tint, in consequence of the irritating effects of the bath and the consequent dilatation of the superficial capillaries. This red coat is less marked in the thermal brine, more marked in the sprudel, and reaches its highest degree in the sprudel-flowing effervescent bath. The therapeutic effects are a diminished size of the heart, a slowing of the pulse, a filling of the arteries, a relative emptying of the veins, enlarged cutaneous capillaries, a diminution in the size of an enlarged liver, and increased diuresis. The baths often bring out latent troubles, as gout, rheumatism, syphilis, etc. By strengthening the beat they sometimes develop a murmur of a previously unsuspected valvular lesion.

The "sprudel-strom"—the effervescing current—is a bath seldom used in cardiac cases, and then only (a rule not without exceptions) after the patient has taken three or four courses of baths during as many seasons. This bath is extremely powerful for both good and evil, and, indeed, this comment is equally true of the other baths regarded as less stimulating and irritating. It is obvious to you all that resources capable of producing good results are also capable of bringing about evil events. This is only paraphrasing that old saying, in a new adaptation, "The greater the poison, the greater the medicine."

In some special cases the baths are the only remedial measures used, and in others exercises are used conjointly with the baths. Again, exercises alone are employed.

## THE SCHOTT MOVEMENTS AND OTHER EXERCISES.

Movements—*i.e.*, exercises—are everywhere regarded as part and parcel of the Bad Nauheim method of treating cardiac disease. Stokes first suggested the use of exercise in heart disease, and also Oertel, whose hill-climbing treatment and liquid-abstention ideas, as practiced, have become unjustly world-wide. I myself, in a paper presented to this body in 1888, without at that time knowing anything of Stokes, Oertel or the Schott brothers, recommended certain of the Swedish movements, under the title of “Suggestions Concerning the Auxiliary Treatment of Simple Cardiac Hypertrophy,” suggesting, also, the use of hot and cold baths, but not exactly, however, as taught by Schott. But, unquestionably, to the Schott brothers, August and Theodore (the former now, unfortunately, deceased) belongs the honor of systematizing and popularizing the system of movements known by the name of Schott, and thereby revolutionizing the treatment of certain forms of cardiac disease, and of killing the idea that no heart patient can exercise without sudden death hanging over him as a possible penalty.

It is true that some other observers had quietly reached the conclusion that exercise was not a cardinal sin, in certain cardiacs, before they heard of Schott; but they were chary of announcing it, and the pall of the former belief still hung over the rank and file of the profession. The heart specialists knew that exercise did not always kill; the general practitioner had inklings of the truth; but the Schotts demonstrated the fallacy of the idea of non-exercise, and proved indisputably that proper exercise decidedly helped certain sufferers from heart disease. Exercise is enjoined, not prohibited, in special cases.

The results produced by these movements in cardiac disease is unquestioned by a keen observer, and are only cavilled at by those who do not know how to use them. In the employment of these exercises, if possible, even greater discrimination is imperative in the class of cases in which they shall be used, and the tact of their performance, than when the baths are given. Briefly, the movements consist (I shall not in this paper consider them in detail) of the use of such movements of the trunk and extremities as shall bring nearly all the muscles of the body into play at different times during the seance, which lasts for

varying periods—usually from half an hour to forty-five minutes. The movements are those of flexion, extension, adduction, abduction and rotation, slowly—never jerkily—performed, with very little expenditure of actual strength, these movements being “*resisted*” by a skilled operator. Exercises of the shoulder, elbow, wrist, and of the hip, knee and foot are performed, each set being moved in groups or sometimes exercised separately; then the corresponding portion is next brought into play. The body is moved forward, backward and laterally. Between each movement (or set of movements, as one arm and then the other) there is a distinct rest of the same length of time as it required to execute the previous movement. Each movement takes about thirty-five or forty seconds. The amount of resistance offered by the attendant is never great. The patient must not be tired by the movements, his breathing must never be much quickened and never seriously embarrassed, and the pulse must not be quickened. The operator must observe all these points—the quickened breath, the increased pulse-rate, cyanosis, palpitation, yawning—and cease at once, the seance being resumed only when all the perturbations of pulse and respiration, or other symptoms induced, have completely subsided. The greatest amount of judgment is required by a skilled operator; he must regulate the resistance exactly to the capabilities of the patient. At portions of the movement where the patient cannot, for anatomical reasons, exert much strength, his resistance is correspondingly diminished. He must never so grasp a limb as to interfere with its normal movement; he must compress no bloodvessel; he must continually correct undue energy, and slow and increase the pace of movements as is best for the individual who is being resisted—all of which require special training.

The effect of these exercises, it is claimed, is to diminish the size of an enlarged heart (the enlargement due to dilatation, primary or secondary to valvular lesions especially), increase the force of the pulse, fill the arteries, deplete the veins, and slow the pulse. The pulse, however, is not so much slowed by the exercise as by the baths. The effect of a single series of movements is often remarkable in affecting all the results enumerated. This effect is, of course, at first only temporary. By a continuation of the resisted movements a new gain is



made, and so, step by step, the heart is restored to full or nearly full functional power. All the symptoms due to defective circulatory strength—mental, moral, physical—slowly vanish. A by-condition is usually noticed also, from the baths more especially, but also from the exercises, and that is an increase in the amount of urine excreted. This additional quantity of urine occurs whether there has been dropsy present or not.

There is also at Bad Nauheim a medico-mechanic (Zander Institute) provided with all the mechanical machines and apparatus required by the system of Swedish gymnastics. The treatment is under the control of physicians and a skilled superintendent. These machine-medicine movements are not a part of the Schott method of treating cardiac disorders. Theodore Schott epitomizes his idea of exercise in this fashion: "Movements without design weaken the heart; movements with design, on the contrary, strengthen the heart." Some of the medical men there employ the Zander Institute, not only in heart but also in other affections. I have not had an opportunity of noting the effect of the exercises at the institute on cardiacs personally, but I have good testimony from an observing physician, who himself took the Zander Institute exercises, that they were without effect upon his heart (a dilated one), while the Schott resisted movements were signally so. The chief objection urged against the machine exercises, in contrast with the resisted movements, is that a mechanical apparatus cannot adapt itself to the natural movements, and give resistance where it is needed in a muscular evolution and fail to give it at portions of a movement where it is not needed. In other words, a machine is not intelligent; it cannot gauge the weak and strong points, and thus fails to produce the result of the Schott movements.

The Oertel system of mountain-climbing can well be practiced at Bad Nauheim, for the town lies at the foot of the Taunus range, and walks of all grades of steepness have been made. The "walking-cure"—the "terrainkur"—is therefore amply provided for. By most of the physicians here, however, the indications for the Oertel treatment are entirely different from those enunciated by the originator of the method. Oertel gave climbing the first place in treatment. Schott gives hill and mountain work the last place in his system, and in this

he is at one with many of the physicians at Nauheim. When a course of baths and exercises, one or both, has restored an impaired heart to competency, then Oertel's treatment is employed to further strengthen and establish compensation. For valid reasons, however, many patients are never permitted to take the Oertel plan. Walks on the level are all they are allowed.

While the baths and exercises are the pre-eminent measures employed in the treatment of cardiac maladies, great assistance, in proper cases, is secured in bringing about a happy ending by the use of adjuvant

#### MINERAL DRINKING-WATERS.

The native drinking-waters containing decided mineral ingredients are four in number, the kurbrunnen, the karlbrunnen, the Ludwigsbrunnen, the Schwalheimbrunnen.

The kurbrunnen and karlbrunnen are the most frequently used, and are effervescent, containing from 1 to  $1\frac{1}{2}$  per cent. of sodium chloride and about one part per thousand of calcium chloride. These two springs are really effervescent saline purgative waters, the kurbrunnen being the stronger.

The Ludwigs-quelle is an effervescent alkaline water, and is not only medicinal but can be used at table as a seltzer water. It contains a small quantity of the bicarbonate of magnesium, calcium, sodium and lithium. The Schwalheimbrunnen is a ferruginous spring, containing much carbonic acid gas.

These waters are employed in kidney and bladder disorders, as well as in gout, rheumatism, lithiasis, chlorosis and anæmia, associated or not with cardiac diseases.

The waters are used to promote tissue change, absorption and excretion of exudates, to stimulate the bowels and kidneys, and to produce a transformation in the blood.

The waters of all the other great springs, as Wiesbaden, Carlsbad, etc., are also kept in the water-drinking gardens, and are prescribed by physicians in proper cases.

The administration of these waters is under medical supervision. When their action is not overlooked they are capable of doing great harm. Stomach and intestinal irritation is not an unfrequent occurrence.

## CLAIMS.

Let us now proceed to a consideration of what is claimed to be done by the Bad Nauheim treatment of circulatory affections. It is asserted that all forms of heart strain, such as is due to injudicious Oertelism, overtraining in gymnasiums, bicycling, etc., are soon remedied. Cardiac weakness produced by smoking, by alcoholism, by an extra accumulation of fat, is included in the list. Nervous affections of the heart, particularly palpitation, and exophthalmic goitre, are well treated at the Bad. Mural degenerations, as myocarditis and pure fatty degeneration, and angina pectoris, are stopped in their downward course, and relative cardiac competency established. The after effects of rheumatic endo- and pericarditis are regarded as especially amenable, and the lesions left after enteric fever and la grippe are said to be speedily removed. The king triumph, however, is the rapid cure of dilatation of the heart. This dilatation may be uncomplicated, or secondary to a failure of compensation in valvular disease. All diseases of the heart, then, dependent upon weakened muscular power are claimed to be greatly relieved, and sometimes entirely cured, by a course or a series of courses of the baths and exercises. Beneke (1859-1872) was the first to make special plea for the efficacy of the baths, but it was only in acute or sub-acute cases of cardiac disease that he at first thought the waters of Nauheim were indicated. He claimed to have seen murmurs, dependent upon recent endocardial inflammation, rheumatic in origin, disappear, and the heart become normal. Every physician at Nauheim has, I think, a case or two of "disappeared murmur" on record. I judge such cases are of extreme rarity. Without wishing in the least to discount the value of the Nauheim claims, I wish to state that cardiac murmurs due to endocardial inflammation, sequential to rheumatism, have disappeared under absorptive treatment, in patients under my own personal care, more than once, and that, too, before I ever heard of the Nauheim treatment.

Murmurs dependent upon muscular insufficiency of the heart, without actual organic alteration in the valves, disappear at the Bad after a course of treatment; that is, so soon as the heart muscle becomes competent. This result I have also ob-



tained without recourse to Nauheim methods. Now, while the Blaine principle of "claim everything" is prevalent at Nauheim, there is not a shadow of doubt that magnificent work is being done every day at that place. I do not wish to detract one jot or tittle from the deserved renown of the treatment. I urge only a judicial consideration. Aside from the experience that I have had in watching cases in the baths, one has only to keep his eyes open to see sights that, to the uninitiated, savor of the marvellous. You see one day some poor fellow get off the train so short of breath that he must be supported, a week or two later walking around in comparative comfort. You see lips and cheeks that were cyanotic gradually become rosy. You see eyes that were anxious and haunted in expression look more contented and interested once more in life. You see feet that were swollen with fluid doff their enormous slippers and wear civilized foot-gear.

Now here is a poser. The results are achieved without the administration of drugs in the vast majority of the cases. Schott seldom, if ever, gives medicine. Occasionally, if a patient is water-logged, he may receive digitalis or calomel. When patients go to Nauheim under the influence of enormous doses of digitalis, the use of the drug is continued for a few days until the baths have commenced their beneficial effects. It is claimed by some of the physicians that the action of the bathing-waters is exactly similar to the action of digitalis; that is, a cardiac tonic, slowing the pulse, increasing the vigor of the ventricular contraction, and raising blood-pressure and arterial tension. With these claims I cannot wholly agree. Digitalis constricts the superficial capillaries; the baths dilate them. Digitalis exhausts the heart eventually; the baths boost and strengthen the heart. Both digitalis and the baths are alike in some points in their respective lines of action. The action of the baths, to my mind, in some particulars at least, is like glonoiné, dilating the superficial capillaries. If we possessed a drug having an exactly similar action on the heart as these baths, there would be no Bad Nauheim method of treatment in existence.

The one great claim of the Schotts that has been most vigorously combated and cavilled at is the assertion that the heart becomes smaller in size during the baths, as demonstrated by

physical signs. This claim has caused more combat than any assertion concerning the Bad Nauheim treatment. First the physical signs were questioned; but examiner after examiner discovered that, so far as could be determined by physical exploration, the cardiac area was lessened in size. When the physical signs were at last believed not to lie, it was asserted that the lungs were possibly emphysematous, caused by the deep respirations in the bath; that the diaphragm was displaced; that the pressure of the bath-water equalized the distribution of the intestinal and stomachic gases, etc., etc., etc., and so made the heart seem by physical signs lessened in size. Radiographs were made, proving the heart not only smaller, but changed in shape; but here the cavillers interposed that the positions were not the same when the radiographs were taken before and after the baths. All this, and much more. Personally, I have satisfied myself many times that the *physical signs indicated that the heart was smaller*. At any rate, whether smaller or not, the other evidence of improved cardiac action is indisputable; and, further, the symptomatic evidence of cardiac incompetency disappears. This is sufficient evidence to me, quite aside from the evident physical signs, that the heart has indeed lessened in size.

#### THEORIES OF ACTION.

The theories concerning the way in which the baths bring about their results have been and still are diverse. The Schotts at first believed in the absorption of the salts, influencing thus the composition of the blood and tissue. Since physiology of a later day apparently teaches the impossibility of skin absorption, it has been held that the solid constituents of the waters, and especially the carbonic acid gas, pass through the outer layer of the skin to the corium, and there act upon the network of terminal nerves in such a manner as to produce a reflex action on the internal organs, the vaso-motor system and the cardiac ganglia, inducing stimulant and, ultimately, trophic action. The nerve irritation is probably partly mechanical, partly chemical, and partly thermic in character. The reflex action is brought about through the sentient nerves in the baths, and the *movements* bring about trophic changes through the stimulation of the motor nerves by the exercises.

## PERMANENCY OF RESULTS.

It has been objected to the Nauheim baths that patients "cured" by this mode do not stay cured. This is perfectly true in a great number of cases, and it is no real objection to Bad Nauheim. The anatomical changes preclude the possibility of absolute cure in some instances. Failure in compensation and simple dilatation, other things being equal, are not unfrequently cured in one course of baths or exercises. When a patient returns home and resumes the habits and brings about the conditions that led to the first serious break, it is nothing more than natural to expect a relapse. Some patients return here, season after season, for the very obvious reason that they cannot get the same measure of relief at home. Other lesions are essentially progressive in character, and their progress can be made a little slower, and distressing symptoms relieved meanwhile. Altogether, the matter may be summarized by saying that, up to the present writing, apparently the Bad Nauheim treatment is the best that can be instituted for certain forms of circulatory disorder.

## INDICATIONS AND CONTRA-INDICATIONS.

In general, it may be said that any form of cardiac disorder in which the muscular power is deficient, or the nervous supply is not normal, can go to Bad Nauheim with benefit. There are two notable contra-indications: Aneurism and arterio-sclerosis—both diseases in which the increased blood-pressure induced by the baths is likely to do harm. The two conditions are, however, benefited in the early stages. Dr. Grædel apparently thinks that even advanced arterio-sclerosis, carefully handled, is capable of improvement. One of the contra-indications, too, is that a patient who will not respond to digitalis should not go to Bad Nauheim. This position, however, is ridiculous, inasmuch as it is daily proven that patients who would not respond to that drug receive distinct benefit from the baths, and, furthermore, after a course of baths, the patient again relapsing, digitalis does bring a therapeutic response. Advanced interstitial nephritis is regarded as unfavorably influenced, although occasionally, in spite of apparent contradiction, the heart and the man improve greatly. Parenchymatous forms of kidney lesion, if advanced, have an increase in the amount of albumin.



Simple albuminuria, due to cardiac weakness, disappears rapidly.

There can be no question that a large number of cases unsuitable to the Bad Nauheim treatment gather there annually, and it is equally true that a goodly proportion of cases are put under the baths and movements that could be treated as well at home. The fame of the place makes the first class possible, and the lack of discriminating knowledge on the part of the general practitioner accounts for the other class.

I cannot close without giving you brief sketches of two notable illustrative cases that I personally investigated among others. The first was a German, 55 years old, who until five years prior to 1897 was a confirmed alcoholic. He had been dropsical all over, been tapped numerous times, had spells of unconsciousness lasting for hours, was once given up as dead, and had a serous apoplexy resulting in hemiplegia, from which he recovered in a few days. He was given up to die by all his attending physicians, and even by the doctors at Bad Nauheim when they first saw the case. The diagnosis was mitral regurgitation, with dilatation of the heart and hypertrophic cirrhosis of the liver. After a very careful and exhaustive examination of this man, and an analysis of his symptoms and history, and giving due weight to the physical signs, my diagnosis was myocarditis, mitral regurgitation, secondary tricuspid regurgitation and sequential engorgement of the liver. This man recovered sufficiently after his first trip there so that he omitted a year; but he has been to Nauheim every season since. While undergoing treatment there he is in comparative comfort. When away he must occasionally resort to digitalis. A physical examination of this man, *even now*, would most certainly lead you to write out his death certificate and leave it with his wife, permitting the date to be blank, expecting that a week at the outside would end the scene. This man certainly would have died with the most accepted treatment of the day. Nauheim's treatment has undoubtedly prolonged his life four years; it has caused diminution in the size of the heart and liver; it has removed dropsy and dyspnoea. It has caused the myocarditic process to stop—so says his physician. His doctor expects him back next year. I do not.

The other case is one I took special interest in. He was a

male seaman, 52 years old, suffering from aortic stenosis, dilated aorta, and dilatation of the left ventricle. He had been found unconscious twice, was not dropsical, but the shortness of breath was so great he could not go half a dozen steps without the danger of falling or fainting. I examined him before he entered the bath. Pulse 90, feeble. Apex-beat one-quarter of an inch outside of left nipple, not appreciable save by deep palpation. Area of cardiac dulness from that point to two and a half fingers' breadth to the right of the sternum. When five minutes in the bath his pulse had fallen to 84, was more tense, fuller, and of much better quality. After eight minutes, pulse 80, fuller and stronger. When he was dried, immediately after the bath, the apex-beat had receded to just within the nipple, the dulness on percussio had diminished by three-quarters of an inch on the left and a finger's breadth on the right, and the aortic second sound was less ringing and the pulmonary second sound not so accentuated. Pulse 85, but good. I have examined this man repeatedly, bath after bath, and noted a gradual diminution in the size of the heart and a bettering of the pulse, which was slower and fuller. His dyspnoea disappeared. I have walked two miles with him on the level without his showing signs of distress. Now, this particular case I feel fairly certain I could have handled at home very well. I have often seen that picture, with and without the aortic dilatation, and have re-established compensation with drugs and hygienic regulations, but I am frank to say that I probably could not have done so in such a short time. He was not given the movements. He did not have a drop of "drugs," not even a glass of mineral water.

I here present his bath-record, in order to give you an idea of the caution employed in their administration:

At this juncture the patient was suddenly summoned home, before the completion of his course of baths. He was advised to return next season, to avoid alcoholics, violent exercise, use a moderate nutritious diet, and walk three hours a day—*i.e.*, an hour at a time—on a level. In reply to a question as to how he felt compared with when he came, he replied: "One hundred per cent better." I replied that such an estimate was incorrect. If correct, he would be well. He said: "I don't care how you figure it out; I know I feel all right, and don't 'blow' any

Day.	Month.	Spring No.	Car- bonic Acid.	Mother- lye.	Tempera- ture. Cent.	Min- utes.
15	July.	7*	With	None.	32½°	8
16	"	7	"	"	"	9
17	"	7	"	"	"	10
18	Pause.					
19	July.	7	"	1 litre.	32°	12
20	"	7	"	1 "	"	13
21	"	7	"	1 "	"	14
22	Pause.					
23	July.	7	"	2 litres.	"	15
24	"	7	"	2 "	"	16
25	"	7	"	2 "	"	17
26	Pause.					
27	July.	7	"	3 litres.	31½°	18
28	"	7	"	3 "	"	19
29	"	7	"	3 "	"	20
30	Pause.					
31	July.	Sprudel.	" 7	None.	Natural.	8
1	August.	"	" 7	"	"	9
2	"	"	" 7	"	"	10
3	Pause.					
4	August.	"	" 7	"	"	12
5	"	"	" 7	"	"	13
6	"	"	" 7	"	"	14
7	Pause.					
8	August.	"	" 7	"	"	15
9	"	"	" 7	"	"	16
10	"	"	" 7	"	"	17
11	Pause.					
12	August.	"	"	"	"	18
13	"	"	"	"	"	18

more." A physical examination revealed a heart still slightly enlarged, the percussion and auscultatory evidences of aortic and cardiac dilatation much less marked than at a previous examination.

#### COMMENTS.

The question naturally arises: What is the exact value of the Bad Nauheim or Schott treatment for chronic heart disease? Some writers, without even putting this interrogation squarely and fairly before them, have immediately jumped into print with the most laudatory commendations, and in their wild enthusiasm over the unquestioned results, have failed to even estimate the vast army of unheard-of, unreported cases that unquestionably would materially alter their supersanguine exultation. A question of this kind must not be decided by

---

\* The "thermal-brine," the one with which treatment is generally first commenced.



enthusiasts. It must be viewed in a cold-blooded fashion, with unwinking eyes, in an endeavor to draw a just conclusion. The general practitioner who has little to do with cardiac disease, and handles his cases with gloved hands, must not be thrown off his guard by unwarranted assertions. Viewed practically, with the eyes of one who has seen considerable of cardiac disease, and from observations made directly on the spot, I must candidly admit that the treatment produces good—I had almost said marvellous—results in a great number of cases. In my opinion the Schott treatment is a distinct, a positive advance in cardiac therapeutics, provided it be properly and discriminatingly applied. Comparing the Schott treatment with the prevailing drug-treatment of the dominant school, the Schott method is by far and away the most effective in point of results, in point of absence of disagreeable symptoms, in point of time. Born of the suggestions of Stokes and Beneke, and developed, evolved, unified and rendered practicable by the labors of the Schott brothers, it is one of the greatest discoveries of practical medicine distinguishing this wonderful age of progress.

It is an insignificant minority, however, who can avail themselves of the benefits of Nauheim treatment. The questions of time, expense, the difficulties of a foreign tongue, the inappetencies of a German table, as well as the ability of the patient to stand not only the ocean voyage, but a long and tedious railway ride, and paramountly, perhaps, the suitability of the case for treatment there, are all questions that have to be carefully weighed before a proper solution of a question of this kind can be arrived at.

The Schott brothers have all along said that the Nauheim baths can be fairly well imitated anywhere, and that nearly equal results can be obtained. I have personally seen several medical men who have obtained results from artificially-prepared baths, together with the Schott movements.

In another paper, soon to be read, I shall treat of the "Bad Nauheim Treatment of Cardiac Disease at Home," and shall give you some data as to the preparation of the baths and the method of the movements.

## SPRAINS—THEIR COMPLICATIONS AND TREATMENT.

BY GUSTAVE A. VAN LENNEP, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Scranton, 1897.)

OF all the injuries to which joints are liable, sprains are perhaps the most frequently met with, and often the most unsatisfactory to treat. Physicians as well as their patients are very apt to make light of an injury of this kind, perhaps losing sight for the moment of the delicate and important structures which suffer damage, and forgetting the possibility of the many and long-lasting complications which are likely to follow such a trifling accident as "only a sprain." A joint once so injured is never as good as it was before the accident, being weak and especially liable to be twisted again on the slightest provocation.

Sprains occur mostly in the ankle, knee, wrist and small joints of the hands and feet, and are due to missteps, falls, or severe twists of the limb while one end rests on the ground. As a rule the violence comes unexpectedly and catches the joint off its guard, that is to say, when the muscles and ligaments are perfectly relaxed; a sprain may, therefore, be justly defined as a momentary dislocation, or, more correctly, subluxation, the part slipping back in place again of its own accord.

The degree of injury inflicted varies according to the amount of force brought to bear on the parts, from a slight stretching of the ligaments to severe and extensive laceration of the soft structures, fracture of the articular cartilages, and even to chipping off of small pieces of bone. When the latter occurs, the injury is known as a "sprain-fracture." Its favorite location is at the ankle, where small particles of bone are detached from the tips of the malleoli.

The synovial membrane is always more or less injured, being unfolded or torn on one side, compressed or crushed on the other, with consequent exudation of serous fluid into the joint. Laceration of the vessels naturally follows, with escape of blood into the synovial cavity and the surrounding tissues. If the hæmorrhage into the joint has been slight, the blood is

readily absorbed and gives no further trouble. If, however, it has been extensive, clots form which become organized, float around in the synovial fluid, or sink into the most dependent portions of the joint. They may also become attached at different points, forming rough surfaces within the capsule or adhesions.

In some cases the tendons escape injury and the muscles are torn, either near or at some distance from the joint. The tear may be confined to individual fibres or extend through the whole thickness of the muscle; the latter is particularly apt to occur at the junction with its tendon. This injury is followed by more or less effusion of blood around the ruptured ends, which later is converted into a lump of granulation tissue, slow to absorb and likely to hamper the action of the muscle.

Again, the tendons may be displaced from their grooves from rupture of their delicate sheaths; this is very often the case with the peronei, and usually occurs after the joint has been sprained a number of times. Moullin claims that if this displacement recurs it becomes permanent. (“Sprains,” p. 88.) A special appliance is then necessary for its treatment.

The ligaments always suffer more or less injury. In severe sprains of the ankle, knee, etc., they are at times torn completely across or wrenched away from their attachments, not infrequently bringing scales of bone with them. In an ordinary sprain, stretching or rupture of individual fibres here and there invariably occurs.

Perhaps the structure that suffers most in an every-day sprain is the soft, delicate tissue that fills up the interstices between the ligaments, bones and tendons about a joint. Through rupture of the numerous vessels extensive hæmorrhage occurs, staining the limb, at times, over an amazingly large area. Moullin states that “the amount of bleeding when a joint is sprained and the rapidity with which the extravasated blood is absorbed are very important factors in determining the speed and the completeness with which recovery takes place.”

The process of repair is the same here as that of an inflammation in any other portion of the body. It begins at once after the traumatism and continues over a period of time corresponding in length to the mischief done the parts. It is always better not to prognosticate how long it will take a sprain



to get well. The character of the parts injured and the proverbial slowness to repair of fibrous tissue, together with the delicate mechanism of joint movements, account for the length of time required for a cure. The fringes at the margins of the synovial membrane and surrounding tissue retain their altered character the longest, and are the last to be restored to their normal condition. If the injury has been severe or repeated a number of times they are apt to become permanently thickened, and continually keep up a certain amount of irritation in the joint.

The treatment of sprains leaves much to be desired. Almost every one is ready to admit that the average results obtained are far from satisfactory. Perhaps the first measure one thinks of is the application of either heat or cold to the parts. Heat is used less frequently for this purpose than cold, as it cannot be kept up but a short time, and its action, therefore, becomes superficial only. The simplest way to use heat is to immerse the injured member in a pail of warm water, then to keep adding hot water until the patient can stand no more. A few minutes is all that is necessary; then the part is carefully dried and a compression bandage applied. This procedure may be repeated a number of times. Heat is much more useful in the convalescent stage, when frequent immersions for a half hour or more at a time produce very good results. Cold is applied to the parts by means of the well-known ice-bag. When used immediately after the injury it lessens hæmorrhage, controls the effusion into the joint and relieves pain. Its action is more penetrating to the deeper structures than that of heat, and it can be continued for a much longer time. As a rule, 24 to 48 hours is all that is necessary. The more rapid the swelling the better are the results from the use of cold. It is contraindicated in the aged, the very young, and in the rheumatic.

The use of plaster of Paris or silicate of sodium dressings is often necessary to immobilize the joint and secure absolute rest. Their indiscriminate or prolonged use must be condemned. The bad results following such methods of treatment are unfortunately frequent. The dressings should be removed at the end of a week, and passive motion and massage given to restore the joint function. If the acute symptoms have not

subsided at the end of that time sufficiently to allow of manipulation, they may be reapplied and left on for another week, certainly not longer.

Perhaps the method that has given the best results is strapping of the joint, immediately after the injury, with adhesive plaster. This was first introduced by Mr. Cotterell, of London, and highly recommended by Dr. Gibney, of New York. (*N. Y. Med. Journal*, February 16, 1895.) The dressing is applied to the ankle as follows:

The foot is slightly elevated, placed at right angles to the leg, and gently rubbed towards the body to deplete it of blood as much as possible. Then, if the external side is hurt, a strip of adhesive plaster one inch wide is applied, starting at the inner border of the foot, near the base of the big toe, crossing the back of the heel, and finishing on the outer side near the little toe. A second strip is then put on vertically, beginning on the inner side of the foot, just above the malleolus, passing under the heel and finishing half way up the outer side of the leg over the tendo Achillis. Successive strips are then put on, overlapping each other one-quarter or one-half inch, until the ankle is completely covered, excepting a narrow space running up the front of the foot and leg. It will be seen that this dressing gives strong support to the ligaments without interfering with the movements of flexion and extension necessary in the act of walking; at the same time it makes pressure over the joint and hastens absorption. If necessary, additional strengthening strips can be applied over the malleoli and up the leg. A gauze bandage is snugly applied over the plaster and the stocking and shoe put on. The patient is now perfectly able to walk, though such exercise should be limited for the first few days. The adhesive is renewed in a week or ten days, two or three dressings effecting a cure. (See Figs. 1 and 2.)

For a sprain of both malleoli, the first strip starts on the inner side of the heel, passes back of the heel, then across the dorsum of the foot, and ends just under the ball of the big toe. The second strip starts at a corresponding point on the outer side of the heel, crosses the dorsum of the foot, and ends just under the base of the little toe; successive overlapping strips are applied until the foot is completely covered. (See Figs. 3 and 4.)

The same principle is applicable to the knee; the strips here

are started parallel to the margin of the popliteal space, extending some distance above and below the joint, and run up each side till the margins of the patella are reached, then from below up over the front of the knee, so as to cross each other, until the lower border of the patella is touched; finally, beginning above the joint, cross-strips are successively applied, covering in the remainder of the free space. A gauze bandage finishes the dressing. (See Figs. 5, 6 and 7.)

Sprains of the wrist, the joints of the fingers and of the back have been successfully treated by this method. In the Hahnemann Hospital of Philadelphia it is the custom to apply this dressing on every sprain presenting itself, and treat the cases as out-patients. As a rule such patients walk about very comfortably with the aid of a cane. The results have been very satisfactory. If a sprain is seen early, the application of ice for a few hours, followed by a gentle rubbing and then strapping, is strongly recommended.

The following cases have been selected from among a number in both hospital and private work, to illustrate the efficacy of this mode of treatment:

CASE I.—A nurse sprained her ankle by falling. She was put to bed and an ice-bag applied to the foot for 24 hours. At the end of that time the adhesive plaster dressing was put on; a day later she undertook the care of a difficult laparotomy, and nursed her case through a prolonged convalescence with no further trouble.

CASE II.—A young lady sustained a double sprain of the ankle by falling from her wheel. She was seen a few minutes after the accident. Swelling and pain came on rapidly and became very marked. Rest and ice-bags, one on each side of the foot, for 48 hours, were prescribed. The adhesive dressing was then applied, and the patient walked immediately with the aid of a cane. In one week's time there was no perceptible limp, though the foot was kept strapped for some time longer. When last seen, about two weeks from the time of injury, motion was perfect and walking painless.

CASE III.—A young man fell from his wheel, severely twisting his knee. He was first seen the day following the accident. There was marked effusion into the joint, with pain on motion, especially when the leg was moved sideways, and one or



FIG. 1.



Adhesive dressing for the ankle. Sprain of outer side. First step. The foot should be flexed to right angle with the leg.

FIG. 2.



Adhesive dressing for the ankle. Sprain of outer side. Dressing completed.

FIG. 3.



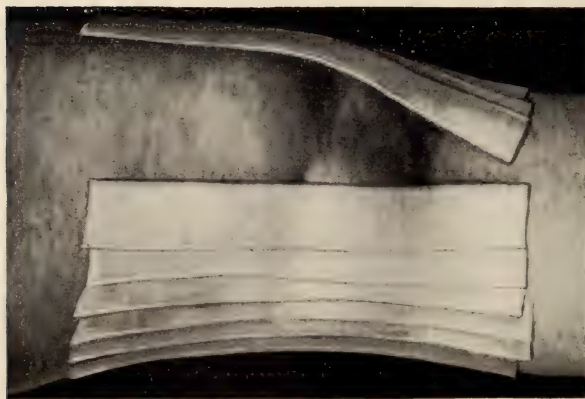
Adhesive dressing for a "double sprain" of ankle. First step.

FIG. 4.



Adhesive dressing for a "double sprain" of ankle. Dressing finished.

FIG. 5.



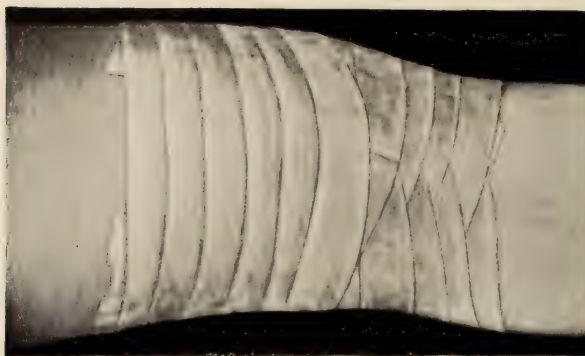
Adhesive dressing for the knee. Lateral strips. First step. These strips run back to the margins of the popliteal space.

FIG. 6.



Adhesive dressing for the knee. Second step. Front lower strips.

FIG. 7.



Adhesive dressing for the knee. Third step. Dressing complete.

two areas on each side and below the patella were tender to the touch. The adhesive dressing was at once applied, with the knee slightly flexed. The patient walked about with a cane. At the end of a week the dressing was removed and the swelling found to have subsided about one-half. A second dressing worn for ten days reduced the joint to almost its normal size. Treatment was kept up for two weeks more, and then the patient was discharged as cured.

CASE IV.—A physician sustained a sprain of the ankle of moderate severity. Pain, swelling and extensive ecchymosis were the prominent symptoms. The foot was strapped, and that night an ice-bag was placed over the tender area. The next day he walked about the city, and in four days more experienced very little inconvenience. Treatment was continued for one week longer, after which time no support was necessary.

CASE V.—A boy sustained a sprain of the ankle by being knocked down by a horse. Swelling and pain were marked, the external malleolus being especially tender to the touch. In this case the adhesive plaster was put on immediately after the accident, and was the only treatment used. In four days the patient was walking about without any difficulty and with but a slight limp. A second dressing, applied in the course of a week, was followed by such marked improvement that he was discharged in fifteen days as cured.

Recently, strapping of the chest, as in cases of fracture of the ribs, has been used with most gratifying results in controlling the sharp “stitch in the side” of pleurisy and pneumonia (Solberg). One or two strips two inches wide, placed over the painful area, suffice to give prompt relief.

In conclusion, it can be claimed for this method of treating sprains that it is readily applied, highly efficacious, does not confine the patient to his bed or house, and does away with the use of crutches.

---

IGNATIA is indicated for the consequences of fright, mortification, chagrin, grief, especially after losing a friend, relative, or the consequences of unhappy love, or for deep, gnawing, irresistible grief, vomiting, gastric symptoms, headache, vertigo, pale face, or even convulsions or epilepsy, especially in children, in consequence of fright or fear.



## A NEW STUDY OF LYCOPodium AND LACHESIS.

BY A. W. WOODWARD, M.D., CHICAGO, ILL.

(Presented to the Homœopathic Medical Society of Chicago, September 16, 1897.)

THE thought to which I invite your intention is this: Can we, by a new interpretation of our drug provings, learn something of advantage concerning the limitations of our remedies, and thereby obtain more practical indications for their use in disease?

In the summer of 1878 the following experiment was made and laid aside, with the provings of several other drugs, as being of no value. Some months afterwards the late Dr. W. H. Woodyatt, after reading them thoughtfully, suggested that perhaps Nature had revealed more than appeared in the few symptoms recorded in these provings.

The day-book reads as follows:

In sound health; pulse, 65. I took five grains 6x trit. lycopodium in solution; soon after, sour eructations; ten minutes later, annoying itching in various parts; again, eructations, with griping and passage of flatus; twenty-five minutes, repeated sneezing, with stoppage of nostrils; thirty minutes, rumbling and distension of bowels, with pinching pains, followed by stool earlier than usual; itching returns at intervals, with perspiration on affected parts; after one hour incarcerated flatus seems to induce cough, with oppression of lungs and husky voice. These symptoms returned now and then for two hours, when there developed a persistent aching and stiffness in lumbar region and hips, as if sprained; soon after there was a call to urinate, which was repeated three times at short intervals; 1 P.M., keen appetite for dinner; ate too much; afterward distension and griping of bowels; 2 P.M., obscured vision, must rub the eyes to see clearly; 2.15, obstructive catarrh in the head; breath smells offensively; 2.35, mental dulness and difficult command of words while lecturing; 5 o'clock, feverish heats, with headache; pulse, 84; lassitude, with cough and expectoration. Flatus and cutaneous irritation continued at intervals for two days, with catarrhal cough, and urination more frequent than normal.

For the Hahnemannian, there was nothing to be learned

from this record; it was simply the reproduction of a few symptoms with which all are familiar. For this reason they had been laid aside. But my friend's remark set me to thinking. Could it be possible that he had seen a new interpretation of our provings, and that the secret concerning lycopodium was not necessarily hidden among the 3100 symptoms of Allen's *Encyclopædia*? The argument in favor of our present materia medica is based upon the dogma that the similia can be found only in a correspondence between the particular symptoms of the drug and those of the disease; consequently, we need a full record of every symptom for comparison. The argument in favor of my friend's insight was that perhaps he had seen, in the natural evolution of symptoms peculiar to this drug, something that might prove to be the only guide necessary for its successful use in disease. If this were so, then the many symptoms in our materia medica were unnecessary.

My first attempts to use this proving as a guide in practice were abortive. Lycopodium was given in a case of bronchitis, with flatulent dyspepsia, with no benefit. It was given in a case of diabetes, with aggravations, at 4 P.M.; results negative. In various other affections it proved a disappointment, until I despaired of solving the problem. Some months later it was tried again in a case of urticaria, evidently of stomachic origin, and a single dose gave instant and permanent relief. During the winter following, the same patient had a severe bronchitis, with some gastric and cutaneous symptoms, and a single prescription cured her. During the summer it was given in a case of renal colic, with red sand in the urine, attended by symptoms of mental failure, and proved to be of no benefit. But in another case, where nephrotomy had been advised, it made an operation unnecessary. This patient had been a martyr to dyspepsia all his life, and exhibited great emaciation, a persistent cough, and marked debility. In this instance not only were the pains relieved permanently, but the patient was restored to better health than he had known for years.

Reflecting upon these results, it was evident that while I had accidentally cured some cases, I had not interpreted this proving aright. I had relied too much upon the special symptoms as given in the books, and neglected to observe the evolution of

effects, one after another, as they appeared in this proving. Reading it again, it became evident that lycopodium could not be curative in mental failure except it was brought about by renal insufficiency. It could not be useful in renal disorders, except they are caused by spinal and respiratory failure. It cannot be of benefit in pulmonary affections except they are caused by cutaneous irritation, while disease of the skin, curable by this remedy, could not arise except from a disturbance of the stomach or the processes of digestion and assimilation; thus the most remote disease forms curable by this agent are directly traceable to its primary action. This must have been the thought in my friend's mind, that the genius of the drug was portrayed in the sequence of physiological disturbance shown in this brief proving; and if this sequence practically agrees with that developed in other provings of record, which is the fact, then we have reached a scientific basis for the use of this drug in disease, and have no further use for a special symptomatology.

Accepting this sequence, therefore, as a guide in therapeutics, lycopodium will be useful: 1st. In primary digestive disorders, when they excite a sympathetic disturbance in the cutaneous, respiratory, spinal and renal organs collectively. 2d. It will be curative in skin affections, when secondary to and attended by gastric derangements, with sympathetic disorder of the respiratory, spinal and renal functions. 3d. It will be of benefit in pulmonary diseases only when there is a clinical history of gastric and skin disease preceding, with symptoms of these parts more or less apparent. 4th. It will be useful in renal diseases, Bright's disease, diabetes, calculi, etc., only when the clinical history exhibits these various functions as having been disturbed one after another in the same order as found in the proving, evidence of which will be found in the collateral symptoms of the case.

It may not be known to you that the early literature of our school of practice gives many cases of remarkable cures by this remedy. The description of some of these indicates most serious pathological conditions, such as it would be impossible to produce by any drug, however poisonous, the symptoms of which cannot be found under any proving. Yet these cases were cured by this remedy in the hands of our fathers, who worked



with an insight beyond knowledge, guided only by the collateral symptoms of the case. Surely we may obtain like results more easily, having the same guidance, supplemented by the clinical history of the case, which will greatly simplify the problem.

Permit me to illustrate my argument by a few cases reported by our seniors in their own words.

*Gastralgia.*—A woman who had formerly enjoyed good health had been suffering for six months with violent pains in the stomach; the pains were made worse by eating or going into the open air; they were attended by cramps in the stomach and constriction of the chest, which arrested her breathing; at times they were attended by headache and vertigo. The bowels were regular. Menstruation during this time had been painful and profuse. *Lycopodium* 30 cured the case in one month.—Dr. Hartlaub—*Beauvais Homoeopathic Clinic*, No. 1794.

*Follicular Tonsillitis.*—Mrs. T. has inflamed tonsils, covered with small, yellow patches; great difficulty in swallowing, with pain on left side, shifting to the right and extending to ear. Attending there was heat alternating with chills, worse about 4 P.M. There appeared during the following night a pemphigus on the thumb and afterward on the finger, with intense burning pains. *Lachesis* did no good. *Lycopodium* cured in three days.—Dr. W. Eggert—*Hoyne's Therapeutics*.

*Deaf Muteism.*—A boy had become deaf after scarlatina in his third year; he had forgotten how to speak. *Lycopodium* 18x was given on account of the otorrhœa, restoring the power of speech and hearing after it had been lost 10 years.—*Homoeopathic Times*, July, 1879.

*Pneumonia.*—Boy, æt. 16, has all the signs of pneumonia involving upper right lung; he has considerable thirst, total loss of appetite, constipation with profuse night-sweats, and is emaciating rapidly, complains of great weakness, coughs a good deal, expectorates bloody mucus. Pulse, 120; temperature, 102½°. *Lycopodium* 200 brought improvement at once.—Dr. J. S. Mitchell—*Hoyne's Therapeutics*.

*Acute Phthisis.*—Mr. B. was taken suddenly with hæmoptysis; examination showed that the upper lobes of the lungs were consolidated. Various remedies were tried for three months without benefit. Consultation decided the case would terminate unfavorably. At this time patient had no appetite, was losing flesh rapidly, had constant pain in lungs, with severe cough, eyes bright and glossy, sunken cheeks with bright-red spots, profuse night-sweats, restlessness, and scant, dark urine. *Lycopodium* 200 gave immediate relief. After the sixth visit sus-

pended all medicines; recovery followed.—Dr. A. M. Cushing—*N. E. Medical Gazette*, May, 1873.

*Rickets*.—L. M., æt. 4, since birth has been dyspeptic and suffered with soreness between his thighs; he was scrofulous to the extreme; aversion to drink between 3 and 4 p.m.; extremely irritable with pain in ankle; bones of left softened, with fistulous opening discharging yellowish water. Under the use of lycopodium 30 the eruption on thighs increased, then began to dry up as the urine became more abundant. Improvement continued steadily; in four weeks he began walking for the first time in his life.—Dr. Marwig—*N. A. Journal of Homœopathy*, August, 1863.

*Morbus Corarius*.—J., æt. 5, has been ailing for some time, frequently falling when on her feet; for two weeks has complained of pain in her knees. Her appetite was lost, she was pale, and had an anxious expression; coughed frequently, with yellowish expectoration; pulse quick and weak; breath offensive; tongue heavily coated; great thirst; urine red with reddish sediment; cries out at night with pain in the limb; feet cold; right leg emaciated; pressure from the heel or over great trochanter causes severe pain; traction relieves; the leg seems elongated and buttock flattened. Phosphorus relieved the cough only. Lycopodium cured in 53 days.—Dr. Hoyne's *Therapeutics*.

*Renal Calculi*.—A man who had long been subject to attacks of renal colic with interrupted urination said they always followed a spree; indulgence in beer or wine was sure to bring them on. Attending there would be severe hæmorrhoids and violent itching in various parts of the body, also catarrhal fulness of head and throat. Lycopodium relieved the pains and stopped the formation of calculi; the hæmorrhoids were increased for a time, but afterward disappeared.—Dr. Kuorre—*Beauvais*, No. 2461.

*Puerperal Tympanitis*.—Mrs. H., three days after her fifth confinement, had enormously distended abdomen. Concomitants, congestive headache and cold feet; great difficulty of breathing, with very weak pulse; later, copious nose bleed; constant backache; lochia completely arrested. Lycopodium relieved at once, restoring the lochia and removing the pains.—Dr. T. C. Duncan—*Med. Investigator*, vol. ix., p. 71.

In reviewing these cases it will be seen that, however various the nature of the disease, the *controlling symptoms* in each were the digestive, the cutaneous, and the respiratory or circulatory. These were the most conspicuous and the most important, excepting the local affection. But it may be said other remedies present the same group of leading features. That is true, and

therefore we must find the *determining symptoms* which govern the selection of this remedy in the spinal and genito-urinary phenomena attending. If these were absent from the case, as appears in some of the records, then some other remedy would have been as well indicated. In contrast with lycopodium, let us study the action of lachesis in the same manner. It should be said that, while it has been well proved, there is little in narrative form by which to verify or correct this sequence. To justify myself, therefore, I would say that it has been verified by several beside myself, not only in private practice but also in public clinics.

*Proving of Lachesis Tri.*

In good health; pulse, 65; took 5 grains 6x trit. in half-ounce of water at 7.15 A.M.

7.20. Itching of the toes; they feel swollen and burn.

7.35. Oppressed and difficult respiration when sitting; nose and eyes watery.

7.48. Much thick saliva in mouth and pharynx; must clear the throat; had no appetite for breakfast. Soon after, right frontal headache, extending later to occiput, with very pale face.

8.10. Feet cold and clammy; shooting pains in region of heart; some apprehension lest I had taken too much medicine.

9 o'clock. Salivation of sticky mucus, with stinging pains in right hand; soon after faintness, with urging to stool, followed by great debility.

9.10. Neuralgic pains down the left arm, with numbness of fingers.

10.10. Pinching in the umbilical region with sinking at stomach, which is tender to touch.

10.15. Repeated and violent yawning, with great sleepiness.

Later. Drawing pains in adductors of left thigh, with weakness in the loins.

11 o'clock. Violent itching of anus; scratching causes voluptuous sensations and erection; soon after a flush of heat all over, with oppression of lungs and desire for fresh air; pulse normal; headache increased at this time.

2 P.M. No appetite for dinner; urination scant, of bad odor; sharp urging to stool, no result.

3.10. Chilly; pulse 84; temperature 100°; soon after, sickening pain in left axilla and chest; urinated, again scant.

4 o'clock. Gripping in bowels, with much soreness; must loosen clothing; passed much offensive flatus; this was followed by burning and itching of anus and other parts; pulse weak and irregular.



4.30. Headache has returned, with great irritability; this was followed by increased mental activity during the evening; there was no desire for sleep before 1 A.M.

2d day. Was sleepy and languid all the forenoon; no appetite for breakfast; great sensitiveness to cold air on going out of doors; violent sneezing.

2 P.M. Much rumbling and distension of the bowels, followed by lassitude; the hands feel swollen and tender; feet icy cold.

3 o'clock. On going out violent convulsive sneezing for some time, causing pain about the heart; pulse 102; very weak; felt exhausted, and alarmed at my condition.

3.20. Free perspiration without cause; in one hour pulse had fallen to 80.

6 o'clock. Sour stomach; no appetite; later, two large and foetid stools, with relief of all symptoms soon after.

You will observe that the sequence of effects produced by this poison is quite different from that of lycopodium. Instead of being, 1st, digestive; 2d, cutaneous; 3d, respiratory; 4th, spinal; and, 5th, renal disorders, this agent disturbs first the cutaneous, then the respiratory or circulatory, then the digestive, followed by mental and spinal phenomena. If this is the sequence of lachesis, we shall find that the cutaneous symptoms are more prominent than the respiratory or circulatory, that the respiratory or circulatory are more urgent than those of the alimentary canal, and that the digestive are more important than those of the cerebro-spinal nervous system, except when that is the seat of the disease. It will also be observed that after the entire system had been invaded by the poison, these various symptoms appeared more or less collectively. In advocating this view of the action of this remedy I recognize that it is a wide departure from the common opinion among us, which considers it a close analogue of lycopodium; but I believe clinical experience will sustain this position. The fact is that every homœopathist is guided to the use of this remedy whenever he finds cutaneous hyperæsthesia or tendency to cyanosis, with respiratory embarrassment, a weak heart, or evidence of rapid disorganization of the blood as the guiding symptoms in the case, taking precedence of all other symptoms in the economy.

There is some reason to believe that crotalus has been dispensed sometimes as lachesis, which will account for the

prominence of the spinal symptoms, such as pains in back and limbs, sometimes mentioned as guiding symptoms by our practitioners, especially in cases of diphtheria. The fact is, these symptoms, together with extreme prostration, are not prominent in this proving until after the entire system has become invaded. Hence apis appears to be a much closer analogue to this remedy than lycopodium, though by reason of the presence of renal and absence of mental symptoms at an early stage, the picture of that remedy is radically changed.

It would require a degree of assurance of which I am not possessed to present these views of lachesis if I was not sustained by clinical evidence from men whose competency to report cannot be questioned.

*Traumatic Gangrene.*—J. C., laborer, was struck on the leg by a heavy box, causing an extensive flesh wound. Inflammation soon set in, and was treated by leeches and poultices. On the third day he was taken with a severe chill, with high fever of several hours' duration, which was followed by persistent vomiting. Soon after, severe pains set in (in the limb), and on the sixth day, when seen by me for the first time, gangrene had invaded both the wound and the leech-bites. He vomited everything; complained of severe headache; was very restless and sleepless; his breath was fetid and his tongue trembling; pulse, 110, small and irregular. I gave lachesis 200. The next day he had retained some nourishment; there was a copious discharge from the wound, which was dry yesterday. On the third day he was improving rapidly. On the fourth day the gangrene had sloughed, leaving a healthy ulcer. Recovery soon followed.—Dr. T. F. Allen—*N. A. Journal Homœopathy*, vol. xl.

*Asthma.*—An old man, otherwise in good health, was frequently seized suddenly with violent attacks of dyspnoea, attended by copious secretion in the bronchia. The attacks were so severe that he could breathe only when leaning forward. Attending this condition there were frequent chills and heat. After a time nausea and retching developed, with cramps in the chest and greatly increased difficulty of breathing. This condition was speedily relieved by lachesis 30.—Dr. Gross—*Beauvais*, No. 277.

*Measles.*—J. B., a well-grown child, had, last winter, scarlatina severely. It left her delicate and deaf. Nine days ago she was exposed to measles. The rash appeared in due time, attended by a copious discharge from the ears. In two days this discharge ceased, and the rash disappeared. She imme-

diately became very feeble and prostrate, and was seized with a wild delirium, attended by great thirst and a biting heat of the skin; the pulse was weak and difficult to count; respirations rapid and moaning; countenance Hippocratic; pupils dilated; breath putrescent. Lachesis 30 was given. In six hours she was playing with her toys. A rapid convalescence followed.—Dr. Carroll Dunham—*Materia Medica*, p. 248.

*Scarlet Fever*.—L. M. had been sick twenty-four hours. I found him with red, swollen face; tonsils, palate and fauces much inflamed and swollen; rash of the miliary form appearing in patches; pulse frequent and irregular. He had lain soporose for over twelve hours, giving no sign of consciousness except an occasional moan. Belladonna was given. For eighteen hours patient was growing worse; the sopor deepened to coma; swelling of throat increased, the rash assuming a darker shade. Lachesis was given. In twelve hours coma was relieved, swallowing improved, swelling diminished. This remedy was continued without change, with a good recovery.—Dr. E. Fish—Hoyne's *Therapeutics*.

*Enteritis*.—Mr. M. was exposed all day to cold and wet weather. At night retired with a high fever, and before bedtime was found comatose; tongue dry and red at tip. He soon began vomiting, with violent pains in abdomen; he cannot bear to be covered; is totally unconscious of every external impression; pulse, 120; respiration, 30; involuntary stools and urine. On the second day the patient, after sleeping, would wake in great distress, throwing off the covers. Lachesis was given with immediate relief of restlessness, the pulse became less frequent, and consciousness returned. In about nine days all fever had left him, and he was convalescent, except that debility remained.—Dr. H. V. Miller—Hoyne's *Therapeutics*.

*Cyanosis*.—Infant two months old. The entire surface of its body was mottled from head to foot. When crying this would change to a decided livid hue; every movement would cause it to cry. The child's breathing, ever since its birth, has been labored, and, when crying, was almost asphyxial; the extremities would become quite cold, and appeared oedematous; in the morning, after waking, dysuria, with urging occasionally. Lachesis relieved all symptoms except the urinary, which required arsenicum.—Dr. C. H. Von Tagen—*A. J. H. M. M.*, v. iv., 30.

The lesson taught by these experiences is this: that there is another method by which a remedy may be adapted to a case by the law of similars besides that of symptom fitting. It means that lycopodium is adapted to any disease whatever, with any symptom whatever, provided the case begins with



digestive, followed by cutaneous, respiratory, spinal, and genito-urinary symptoms of some kind, associated with the local affection; and later, it may be useful at any stage of any disease, provided these associated symptoms present this relative degree of severity. Again, this lesson means that the usefulness of lachesis does not depend upon the special symptom, but upon a group of general symptoms, which indicate that the cutaneous and respiratory functions are chiefly involved, these being associated with other symptoms, indicating that the digestive, mental and spinal functions are also disturbed. In other words, the homœopathic totality of indications will hereafter be found more certainly in *a group of disturbed functions* rather than in *a group of special symptoms*. And if it should be found that each group of disturbed functions stand for one particular remedy, as seems probable, we will have taken one more step towards practical and scientific therapeutics.

---

### CONGENITAL AMBLYOPIA.

BY W. H. BIGLER, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Scranton, 1897.)

IN treating of the subject of amblyopia we wish to exclude from consideration all those forms dependent upon abnormal conditions recognizable by objective examination. We leave out of view, therefore, all those forms resulting from changes in the refractive media, whether the consequence of injury or disease—corneal or lenticular opacities; all those forms, too, accompanying systemic affections, hence such as poisoning from alcohol or tobacco. We confine our study, therefore, to congenital amblyopia, which we have no hesitation in believing lies at the bottom of all the other forms, except those which are sometimes, but wrongly, classed as amblyopias, but which are merely the result of mechanical interference with the entrance of the rays of light. That these can hardly be ranked as amblyopias is evident from the observed fact that after the removal of a cataract which has been present for as long a time

as twenty years, the acuteness of vision in the retina has been found to be normal.

The amblyopia to which we have special reference is that subnormal acuteness of vision which we find existing in an apparently perfectly normal eye, the true nature of which has not yet been definitely determined. Authorities are not yet agreed whether it resides in the percipient layer of the eye, the retina, or in the conducting power of the optic nerve, or, finally, in the percipient visual centres in the cerebrum. As we shall see further on, the latest investigations into the growth and development of the nervous system are furnishing many significant data having a direct bearing upon the determination of this question.

We have all no doubt in testing the refraction of our patients been struck with the fact how very rarely we find one in whom the acuteness of vision is alike in both eyes. We may, after the most careful examination, find that the refraction of the two eyes is the same, and yet that there is a difference, sometimes greater, sometimes less, between their respective acuteness of vision. We think that a careful questioning will find this to be the fact in the majority of cases. The difference may be very slight, so slight as scarcely at first to be perceptible to the patient, but by rapidly closing first the one then the other eye it will become evident. Frequently this amblyopia may be so trifling that the same line of the test-card can be read, but with a feeling of a certain want of strength or directness of vision in the one eye not noticeable in the other. The feeling is analogous to that experienced when attempting to perform with the left hand work usually done with the right, and it is with this analogy that we have been in the habit of quieting the anxiety of our patients, naturally excited by a suddenly recognized defect in vision.

This analogy is, we think, more than a mere superficial one. We are unfortunately unable to say which eye, the right or the left, is most frequently amblyopic. It would be not only an interesting but a profitable line of inquiry to determine this point, as well as the question whether and in how far it is modified by the right- or left-handedness of the individual, and whether a cultivated ambidexterity would prevent or assist in curing this form of amblyopia.

Even when both eyes are amblyopic we will usually find one a little more so than the other, although in our experience this has not been so nearly uniformly the case as where one eye has normal acuteness of vision.

Starting with this congenital amblyopia, the development or not of a higher degree, and amblyopia ex anopsia, will depend upon certain circumstances. If the difference between the eyes is so great that the poor vision of the one tends to lessen the acuteness of binocular vision, the cerebrum instinctively suppresses, or, better, ceases to become cognizant of the impulses received through the amblyopic eye, until, from want of use, its vision will deteriorate more and more, and finally may be practically lost. If there is a want of stability in the equilibrium of the external muscles of the eyes, a slight amblyopia of the one will be sufficient to weaken the reflex impulse necessary to produce and maintain proper convergence of parallelism of the visual axes, and we have strabismus resulting. At first this will be intermittent and alternating, but if combined with any decided refractive error it will soon become permanent and monocular, the more amblyopic eye being the one naturally fixed. From this condition we have as a necessary result a constantly increasing amblyopia from disuse.

The constancy and rapidity of the occurrence of these changes depend, further, much upon the habits of the person. Where the eyes are used principally for distant vision, or where perfect distinctness of vision is not demanded, these consequences do not so invariably follow.

An explanation of these facts and valuable guides in the treatment of these conditions, both as regards prevention and cure, will be found in the results of recent investigations into the minute anatomy of the nervous system, its growth and development and decay.

The following points have been established by these researches :

The number, as well as the intensity, of our sensations and perceptions depend upon the number and connections of the neurons, nerve-cells and nerve-fibres.

The number of these increases from birth to about the thirty-fifth year, remains stationary then from fifteen to twenty years, and finally begins to decrease by atrophy. By actual count,



between the sixteenth month and the thirty-fifth year the nerve-fibres and cells have been found to increase 1300 per cent.

Given normal nervous elements, their specific excitation will result in healthy growth and increase, while want of use will cut short their development and finally cause their atrophy.

Although these facts have been demonstrated in the eye, as far as we know, only in regard to the development of the color-sense, yet we think we are justified in accepting them as applicable to the whole phenomenon of visual perception.

Since, then, perfect vision is the result of the normal development of the normal nervous chain whereby the vibrations of the ether are received, conveyed and translated into what we call sight, a congenital subnormal acuteness of vision will be dependent upon some abnormality in this chain. This abnormality consists, no doubt, most frequently in imperfect development, the result of conditions of our habits and civilization which have long been operative, just as in the analogous case of the almost universal prevalence of right-handedness. But a very small part of the myriads of nerve-elements capable of development are ever brought into play by our present methods of education. As we have just seen, such imperfect development may in a great measure be remedied by the application of the proper stimulus. Fortunately, no matter in what part of the nerve-chain concerned in vision this imperfection may reside, stimulation of the retina will tend to excite and develop all the other fibres and cells, so that we have in this the fundamental indication for treatment — systematic stimulation by regulated use of the eyes.

Since growth and development continue only for a certain number of years, after these have passed we cannot look for improvement, and should be, therefore, the more anxious to begin the treatment at as early an age as possible. In the years of infancy and childhood the prospects of a successful treatment are more encouraging, while the dangers of irremediable complications are more imminent. The first discovery of a congenital amblyopia should be the signal for at once instituting systematic exercise of the visual function. It must be systematic and based upon the knowledge that the purpose of such exercise is directly to stimulate certain nerve-elements through the agency of light, and should be applied with the

same care and forethought as electricity in the treatment of paralysis.

Of course where there is considerable refractive error this must be corrected, so that the stimulus to the retina may be as energetic and precise as possible. Where strabismus has already resulted it must also be corrected, either by tenotomy or by the use of mydriatics and correcting-glasses, being careful to avoid prisms. In high degrees of amblyopia the exercises will be at first by large, brightly-illuminated objects; in lower degrees by smaller and more indistinct objects. As in bodily exercise, so here, a healthy fatigue is desirable and beneficial, while fatigue amounting to exhaustion, even if of but short duration, must be avoided.

It is not impossible that we may be aided in our efforts by the administration of internal remedies, probably the so-called "tissue remedies," and of these we would think first of *magnes. phos.*, *kali mur.* and *kali phos.*

---

#### THE PATHOGENIC ACTION OF KALI CHLORICUM ON THE KIDNEYS.

BY F. H. PRITCHARD, M.D., WEAVER'S CORNERS, OHIO.

THE action of this remedy upon the kidneys, though known, does not seem to have been often tested in homœopathic practice. In the majority of text-books on homœopathic materia the pathological basis of the toxic affection is stated to be a catarrhal nephritis. This is possible; for, though it is useful in certain varieties of typical nephritis, the kidney-changes appear to be secondary to important alterations in the blood itself. The characteristic changes, as described by R. Lenzmann (*Ueber einige den Arzt interessierende Nierengifte und die durch dieselben hervorgebrachten Veraenderungen in den Nieren*, Festschrift zur Feier des 50-jährigen Jubilæums des Ver. d. Aerzte des Reg.—Bez. Düsseldorf, p. 147) would lead one to think that, unlike many other drugs, an irritative, inflammatory state it does not produce, but that the function of these organs being to excrete certain discarded materials which arise in the body under the action of the chlorate, and in trying to

protect the system from danger by this excretion it becomes overworked, eventually its functions suspended, and thus life is endangered. The substances mentioned result from an injurious influence of the drug upon the red blood-corpuscles. Their hæmoglobin is transformed into methæmoglobin, so that a destruction of the red corpuscles is the consequence. At the same time the blood takes on a peculiar dark-brown color, and loses its property of becoming red on exposure to the air. If death takes place in a short time—a few hours—then no changes are found in the kidneys, except that they are hyperæmic and the glomeruli and the tubuli contorti are distended with peculiar, brown-colored, red corpuscles that are undergoing disintegration.

After some time, however, when these organs have lost their ability to excrete the disintegrated corpuscles, the characteristic changes are observed. The kidneys are enlarged, present a grayish-brown to reddish-brown color; on section not infrequently radiating dark-brown streaks are noticed in the cortex, which may partially extend into the medullary portion. In grave cases the kidney is entirely and uniformly a chocolate-brown in color, so that no radiating streaks are to be seen.

Microscopic examination shows the glomeruli and the tubuli contorti to be filled—especially some time after poisoning—with small, glistening, brownish, globular or irregularly-shaped bodies; these are the broken-down red corpuscles. In intense poisoning cases they are actually baked and pressed together into regular casts, which fill out the tubules. Often they are so compressed that they appear almost homogeneous. Not rarely a number of globules are seen to be arranged together in the tubules like a string of pearls. As a rule, the epithelia themselves are *not* affected, though, from pressure, the sides pointing towards the lumen of the tubule may be granularly degenerated. Neither epithelial swelling, turbidity, fatty degeneration, nor desquamation takes place. The urine, as might be expected, is very scanty, of a dirty-brown color, and in its sediment the mentioned broken-down red corpuscles are observed. Spectroscopically, this has been shown to be methæmoglobin. Albumin is also to be detected, yet nothing that would lead one to conclude that an inflammation of the kidney had occurred. If the victim does not perish from the immediate con-



sequences of the poisoning—the destruction of the blood—then death may follow with the symptoms of suspended renal function, from uræmia. In other cases, with increase of the quantity of urine, the accumulations are swept out of the kidneys, and recovery follows.

Kobert (*Lehrbuch der Intoxikationen*, p. 477, Stuttgart, 1893) divides the action of the drug into two varieties: an acute and a subacute. In the former, where poisoning has occurred from ingestion of a large quantity at once, death takes place from immediate destruction of the blood—methæmoglobinæmia; the renal alterations are then but little pronounced. In the subacute form death usually takes place some time after poisoning, when the following phenomena are observed:

1. Grayish-violet spots appear upon the skin, with icteric discoloration, some days before death; methæmoglobin is detected in the blood, the red blood-corpuscles are altered, and there are great dyspnœa and weakness of the heart.

2. There are gastro-intestinal disturbances: violent diarrhœa, obstinate vomiting of blackish-green matters, swelling of the liver and kidneys.

3. The functions of the kidneys are disturbed; there is long-lasting oliguria and anuria. The scanty and turbid urine varies from a reddish-brown to a blackish color; it contains methæmoglobin and hæmatin, as well as large quantities of albumin. At first, microscopically, hyaline casts are to be detected, as well as numerous masses of detritus of red blood-corpuscles, in the form of broad and brown casts or of yellowish-brown masses. The chlorate may be discovered in the urine unaltered or reduced to the chloride of potash.

4. Disturbances of the nervous system, with uræmic symptoms, as delirium, confusion of the sensorium, coma, obstinate vomiting, tonic and clonic spasms, and rigidity of the extremities.

Subjectively the patient complains of headache, anorexia, sensitiveness or pain in the region of the stomach, especially on pressure; painfulness of the liver and lumbar region, intense dyspnœa, and a feeling of great prostration and weakness.

In what kidney diseases would this remedy seem to be indicated, homœopathically? First and foremost, in hæmoglobinuria, as that accompanying scarlatina, yellow fever, typhoid

fever, malaria, and syphilis. It might also be of value in that form following severe burns, exposure to severe cold, or violent muscular exertion, as well as in the paroxysmal form of the disease. In Raynaud's disease there is also a paroxysmal form where the drug might be indicated. But the symptoms most closely correspond to the *epidemic hæmoglobinuria of the new-born* where the symptom is associated with jaundice, cyanosis and nervous symptoms.

It will possibly be found of value in certain cases of renal insufficiency from overloading of the kidneys through functional insufficiency of another organ, as of the liver, where the urine is dark, scanty and loaded with the products of imperfect metabolism, and presenting the characteristic reddish-brown appearance. In pregnancy, where the kidneys fail and the urine takes on this appearance, it is said to have been found of value. I have seen recorded such a case where the urine cleared up under its use, but I cannot find the report.

Prof. Goodno, *Practice of Medicine*, vol. II., p. 366, states he has obtained positive results with this drug in hæmoglobinuria, giving it persistently in the third to the sixth decimal. In decomposition of the blood, as in infectious disease, with consequent hæmaturia, he suggests the administration of kali chloricum, classing it with such drugs as lachesis, crocalus and arsenicum.

The mentioned observer, whose text-book is an honor to American medicine, has seen this chlorate prove of service in rapidly-progressive cases of chronic diffuse nephritis, with a high degree of anæmia. The patient is pale, breathless, and has much palpitation. The urine is scanty, highly albuminous, and may contain blood-cells. He then goes on to say that remedy is thoroughly homœopathic to this lesion of the kidneys, but for some reason has never claimed much attention as a remedy for Bright's disease. It often exercises a prompt influence over the amount of albumin and the other urinary evidences of the activity of the lesion. He employs it in triturations from the first to the third decimal. One German writer, in commenting on a case of poisoning by this drug, calls it a true "kidney-poison"—Nierengift.

## SERUM-THERAPY.

BY P. SHARPLES HALL, B.S., M.D., PHILADELPHIA.

Professor of Pathology and Director of Histological Laboratories, Hahnemann Medical College, Philadelphia.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Scranton, 1897.)

IN presenting to you the following case, a cure unfortunately cannot be recorded, the desire being to place the case on record, and from it, if possible, draw conclusions which, in the future, may lead to relief and cure of these unfortunate subjects.

The case in question is one of sarcoma of the neck. The treatment used—inoculation with the toxine of erysipelas and prodigiosus. A good deal has been written upon this subject, both in this country and in Europe; but the most extensive articles are those by Dr. W. B. Coley, of New York, owing to whose untiring efforts and researches more than one case is to-day not only alive but well, while many others have received relief and passed their latter days in comparative comfort.

In 1884 Dr. Coley was treating a case in the hospital wards who was suffering with a sarcoma of the neck very similar to the case here reported, and, like it, operation had been refused as impossible, owing to the situation of the growth and tissues involved. While the case was under treatment, an attack of erysipelas occurred in the tumor. Soon it was noticed that the size of the growth began to diminish; the erysipelas was watched, but allowed to continue. Upon its disappearance, the growth was reduced about one-half. A few days later a more severe attack of erysipelas occurred, which, for a time, threatened the life of the patient. With the second attack the tumor rapidly diminished, and finally disappeared. Seven years later (1891) the man was well, with no recurrence, an extensive scar only remaining. Noting at the time the apparent curative effect of erysipelas on the tumor, Dr. Coley decided to try the action of erysipelas artificially. Here he found it difficult, often impossible, to produce erysipelas, even with virulent cultures, and also difficult to control it when once the disease was started.



The first serum was prepared by taking a bouillon culture from a fatal case of erysipelas, after ten days, sterilized by heating to a temperature of  $100^{\circ}$  C. The resulting symptoms and reaction were almost the same as from living cultures, but less severe and shorter in duration. In order to improve the serum, and, if possible, make it more effective and safer, the soluble products were tried, procured by passing living bouillon cultures through a Kelasato filter. The use of the filtrate gave a reaction similar to the sterilized culture, but less severe and persistent. The results from this serum not being satisfactory, a third was prepared by adding to the erysipelas streptococcus the bacillus prodigiosus; bouillon cultures of erysipelas were allowed to grow for ten days. Then was added the prodigiosus toxine, and the two were allowed to grow for ten days longer. The resulting culture was then heated to  $58^{\circ}$ – $60^{\circ}$  C. for one hour, to render sterile, but not filtered. In order to keep the resulting serum, a few thymol crystals were added. This latter serum is the one Dr. Coley has used for several years, and was the serum used by us in the case here reported. It was procured direct, through the kindness of Dr. Coley.

The case in question was admitted to the Hahnemann Hospital, under the care of Dr. W. B. Van Lennep, January 29, 1897, suffering from a rapidly growing tumor of the neck. The history, as taken from the hospital record, is as follows:

B. F. L., married, French, *æt.* 44. Family history negative. Personal history, always enjoyed good health until present illness. History of present illness: About six months before admission, noticed small swelling at angle of left jaw; it has increased gradually in size, until now it measures  $2\frac{1}{2}$  by 3 inches in diameter (see Plate No. 1). Apex is red and discharges small amount of pus; very sensitive over entire growth. Pain almost constant. Throat sore, causing difficulty in talking and swallowing. Tongue coated white. Left chest sensitive to percussion. Patient fairly well nourished. Pulse, 88; temperature,  $99.6^{\circ}$ . Respiration, 18. Taken to dispensary on February 3d, and examined in throat department by Dr. H. S. Weaver, who returned the following report:

“Apparent involvement of pharynx shown by an ulcer just back of left tonsil, and probably some thickening of left arytenoid cartilage.



PLATE No. 1. See page 42.

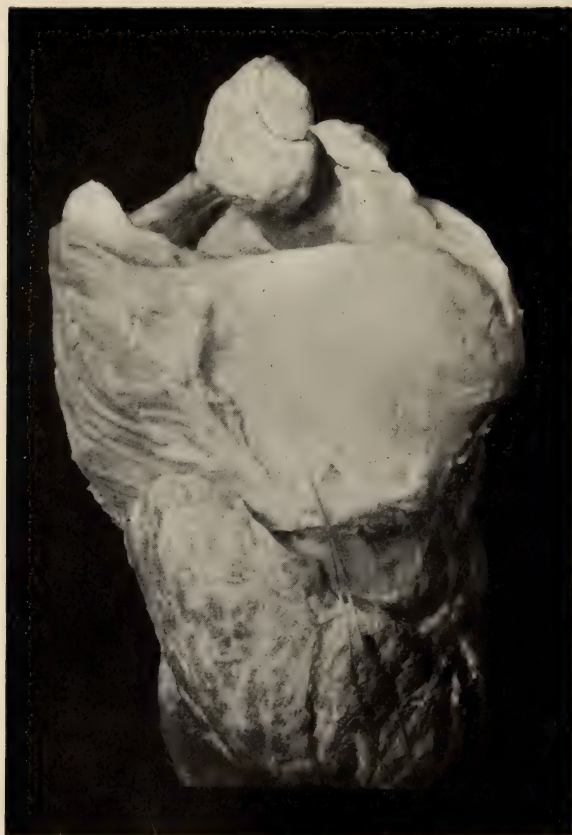


PLATE No. 2. See page 46.



"On February 6th the patient was examined under ether by Dr. Van Lennep, and a small portion of the growth removed for microscopical study. It presented a large, fixed, rather hard tumor on the left side of the neck, involving the greater part of that side of the neck, of brawny color, beginning to ulcerate at its most prominent portion. Evidently the large bloodvessels were implicated; besides, the growth was found to have spread to the tonsil and to the left side of the pharynx. Operation was, therefore, deemed impossible."

A small piece was removed and sent to the pathological laboratory, from which is the following: "Tumor composed principally of small round cells containing distinct nuclei; stroma delicate and scanty; bloodvessels numerous, thin-walled; in many cases walls composed only of tumor-cells; considerable free blood in the tissue. *Diagnosis*: Small, round-celled sarcoma."

The examination of the urine throughout was negative.

The case being inoperable, it was decided to use the serum treatment, although the subject was considered hopeless. Through the kindness of Dr. W. B. Van Lennep, the case was transferred to the medical ward and placed under my care. The first inoculation of serum was given March 1st, at which time the tumor had increased in size until it measured about five inches in diameter. It projected beyond the line of head, displacing the ear upwards and outwards. Upon the apex were three ulcers about the size of a five-cent piece. These were discharging a dirty, thick, yellowish pus, which covered the bases of the ulcers. The tumor was very sensitive, pain almost constant. The condition of the throat was such that swallowing even of liquids was almost impossible. Nutrient enemata were ordered in addition to food taken by mouth. The pulse and temperature had gradually increased, the temperature varying from 98.4°-99.6° in the morning to 100°-101° in the evening, and twice had reached 102°. Pulse from 80 to 120. The patient was cachectic and markedly emaciated. Morph. sulph. or sulphonol had been given nightly, so that he might sleep. This was continued throughout treatment.

On March 1st, at 4 p.m., the first inoculation was given, consisting of  $\text{m} \frac{1}{2}$  ss. of serum injected directly into the body of the tumor. This caused excruciating pain. At 4.30 p.m.

patient complained of a chill, lasting ten minutes, followed by free perspiration; felt tired, and complained of considerable pain. Temperature,  $103.8^{\circ}$ ; pulse, 110. Refused food. Sleep was broken. On March 2d the second injection was given, consisting of  $\text{m}\ddot{x}$ . ss.; this was much less painful; the tumor seemed softer; the pus covering ulcers had entirely disappeared; the three ulcers had merged into one. There was considerable discharge of a straw-colored serum. There was no chill following this treatment. Temperature,  $102.6^{\circ}$ ; pulse, 104. Patient took some nourishment and had a better night. The third injection was given at 4 P.M. on March 3d; also  $\text{m}\ddot{x}$ . ss. As on the day before, there was no chill. Temperature,  $101.6^{\circ}$ ; pulse, 106. The patient took almost the same amount of nourishment, but slept fairly well all night. As there was no decided reaction following after the first inoculation on March 4th at 4.30 P.M., the injection was increased to  $\text{m}\ddot{x}$ . j. at 5.30 P.M.; a severe chill, followed by free perspiration. Temperature,  $105^{\circ}$  in axilla; pulse not taken. Patient refused his supper, but passed a fairly comfortable night. The tumor had by this time become quite soft and discharged freely a yellowish serum, but no pus. The decrease in size of tumor was noticeable. On March 5th patient was very hungry, but owing to difficulty in swallowing he took very little food. At 4.20 P.M. another inoculation, consisting of  $\text{m}\ddot{x}$ . j., was given. One hour later he complained of a severe chill, lasting twenty minutes, and followed by free perspiration. Temperature,  $103^{\circ}$ ; pulse, 110. Patient slept very little during the night.

On March 6th the dose was increased to  $\text{m}\ddot{x}$ . ij.; one hour later a chill, lasting twenty minutes, occurred, followed by free perspiration. Temperature,  $102.4^{\circ}$ ; pulse, 126. At 3 A.M. the dressing was saturated with blood; complained of feeling chilly. Temperature,  $95.6^{\circ}$ ; pulse, 80; the temperature gradually rising to  $97.6^{\circ}$  by 7 A.M.; pulse, 102. Under these circumstances no inoculation was given on the 7th. Patient about the same. Highest temperature,  $100.6^{\circ}$ . On March 8th the amount of serum was increased to  $\text{m}\ddot{x}$ . vi., without any reaction. Highest temperature during the day,  $100^{\circ}$ . Slept well. Could take but little nourishment on account of difficulty in swallowing. The tumor had decreased one-half in size, ulcerating over entire surface; discharge of serum very profuse, necessitating

several changes of dressing daily. Very soft and small pieces were removed with dressings.

On March 9th the dose was again increased to cc. ss. Still no reaction. Temperature,  $100.6^{\circ}$ ; pulse, 100. Took more nourishment. Slept only in short naps. No injection was given on the 10th; amount of nourishment about the same. The highest temperature was  $101^{\circ}$ ; pulse, 100. On the 11th another injection of cc. ss. was given; no chill followed. Temperature,  $101.8^{\circ}$ ; pulse, 100. Appetite much better; slept soundly until 4.30 A.M. without any narcotic. The injection was increased to  $\text{m}\ddot{x}$ . x. on the 12th; this was followed by a slight chill, with free perspiration. Temperature,  $102^{\circ}$ ; pulse, 120. Slept very little, but appetite good. Tumor sloughing rapidly; only slightly raised above the surrounding surface.

The patient was taken into the clinic on the 13th and  $\text{m}\ddot{x}$ . xii. were injected. In removing the dressing two large pieces of tumor came away with the dressing. The patient said he could swallow better; less pain and slept better. No chill followed this, the largest dose given. Highest temperature,  $100^{\circ}$ ; pulse, 106. Slept very little. Following this large dose there was some depression, so inoculations were discontinued until the 16th, the highest temperature being  $100^{\circ}$ ; pulse, 96.

On the 16th the last inoculation was given, consisting of  $\text{m}\ddot{x}$ . x. One hour later there was a severe chill, lasting ten minutes, followed by free perspiration, temperature only rising to  $101^{\circ}$ ; pulse, 100. Sleep was sound until 4 A.M. From now on patient sank rapidly, swallowing became impossible, and patient refused nutrient enemata. Gradually became weaker, and died on the 22d.

Report from autopsy (March 23d) is as follows:

Patient very much emaciated. A small swelling over sternum at junction of third rib on right side; an ulcerating mass on neck, left side, measuring four inches in diameter, the tissue being soft and easily removed with the hand, exposing the larynx and opening into the œsophagus, the upper third of which was entirely destroyed. In the centre of the mass in the neck was a piece of tissue about the size of a hen's egg, which was moderately firm. The large vessels, nerves and muscles in the region of the growth in the neck were entirely destroyed.



Upon opening the thorax a mass, degenerated like the one on the neck, was found at the junction of the second and third costal cartilage and sternum, the cartilage and part of sternum being destroyed. The left lung was consolidated—secondary pneumonia—and studded with metastatic tumors, most of which were broken down. In the larynx there was a tumor, almost completely filling the passage and resting upon the vocal chords, freely movable, attached to the left vocal chord, posteriorly, by a small pedicle (see Plate No. 2). This tumor was firm, white, oval, and conformed to the shape of the cavity of the larynx. The œsophagus in the upper third was degenerated and could not be removed, except in a degenerated mass. The remaining organs of the body, with the exception of the entire absence of adipose tissue and being very anæmic, were apparently normal.

*Diagnosis.*—Death from exhaustion, following sarcoma of neck, with metastatic growth in larynx, left lung, costal cartilages of right side, second and third ribs. Taking into consideration the rapidity of the growth and the weak condition of the patient at the time the treatment was begun, it will be seen that the case was practically hopeless. We tried inoculations simply as an experiment, and the results were such as I believe will recommend it in the future, not after the disease becomes generalized, as in this case, but early. The knife at the best is only temporary relief, while the use of the serum, as records show, has resulted in permanent cures. In the case under discussion, the serum certainly had decided action. The tumor on the neck softened, broke down, and practically sloughed away. Had this been the only growth, I firmly believe the case would have been cured. Even in the metastatic tumors, with the exception of tumors in the larynx, the disintegration of the tumor cells was unquestionably due to the action of the serum.

The best results obtained have been in cases of spindle-celled sarcoma, although all varieties of sarcoma, and also of carcinoma, have been treated with more or less success. The action of the serum on the cells of the tumors was characteristic and decided. All the tissues removed, with the exception of the larynx, have been examined microscopically. The larynx was removed entire, and given, uncut, to Dr. R. B. Weaver, for the museum. The appearance, under the microscope, of the

several tumors was practically the same. Near the centre, where the tissue was firm, was a small, round-celled sarcoma. As sections were cut nearer the periphery, first the protoplasm of cells began to show degenerative changes, the nuclei being set free in the tissue. Later, these, with stroma, degenerated, leaving a mass of tissue without structure.

---

### THE HOMŒOPATHIC USES OF CINA.

BY CHARLES MOHR, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Scranton, 1897.)

FOR centuries the flower-heads of the Aleppo or Levant *artemisia contra*, introduced by the Crusaders, was used only for the expulsion of the lumbrici of children, and became commonly known as wormseed. The doses were large, becoming smaller as its effects were better understood. From sixty- to ten-grain doses were those ordinarily employed, until after the discovery of the proximate principle, *santonin*, which almost entirely displaced the use of the flower-heads, in doses of from one-half to two grains. Both *cina* and *santonin*, in the larger doses, proved dangerous, and even fatal, so that latterly the active principle was administered more carefully; and, on account of its not being readily dissolved in the juices of the stomach and intestines, some portion of the drug was expelled by the administration of castor oil or a saline purge. It remained for Hahnemann, in 1829, to place *cina* before the medical profession in its proper connections; and after the study of its effects as it had been theretofore employed, and especially after a careful proving, he was prepared to say, "This vegetable substance has much more valuable properties, which may be inferred from the subjoined characteristic morbid symptoms produced by it in the healthy." As is the case with every drug proven by Hahnemann, the study of the pathogenesis of *cina* will well repay the practitioner; and, if its administration is in accordance with the rules of homœopathy, multitudes of patients will experience the beneficial effects of this agent.

Even by homœopathic practitioners *cina* and *santonin* are

looked upon merely as destroyers of worms, especially of the round variety, and for this purpose too large doses are yet given; and, worse than all, the active principle is given without the precaution taken by the old-school practitioner when he prescribes it.

It certainly is a fact that the vast majority of the cases cured by *cina* are found in children who have worms, either of the round variety (*lumbroides*) or the thread variety (*ascarides*), although Farrington, in his *Clinical Materia Medica*, is made to say that for the latter *cina* is no good. It really matters little, however, whether worms are present, have been present, or have never been present, to constitute *cina* a homœopathic remedy, if the symptoms of the sick to whom it is administered correspond to the symptoms of the pathogenesis as given in the *Materia Medica Pura* of Hahnemann. I have verified this in hundreds of cases, as did also practitioners of homœopathy like Hering, Lippe, Guernsey, Raue, Dunham and Farrington.

I will briefly allude to the classes of cases curable by *cina*, and thus hope to lead to its successful employment by those of our colleagues who know only of its virtues as an anthelmintic.

First, the cachectic. Children, and even adults, who may have had worms or intermittent fever, who invariably complain of pains in the belly, whose abdominal organs are deranged functionally, and who suffer nervously, as do those whose intestines are actually infested with worms.

Second, the anæmic. Children (and adults, again,) who have suffered from indigestion and non-assimilation of food, or have become anæmic from some acute illness, especially when they suffer much with headache, vertigo, and neuralgia.

Now, in these two classes we will find many patients who have specialized diseases of the visual, nervous, respiratory, digestive and sexual systems, and I may profitably mention some with the leading characteristics calling for the administration of *cina* 1x to 60x.

*Asthenopia* as a result of masturbation or onanism, when reading by artificial light is next to impossible; the eyes feel as if veiled, requiring constant wiping, and sometimes violent rubbing to relieve the veiling.

*Strabismus* of the spasmodic variety, always induced from some abdominal irritation.



*Prosopalgia*, involving the supra- and infra-orbital nerves and facial distribution over the zygoma, and sometimes extending to the infra-maxillary region. The pains are pressing, screwing and excruciating, with much cutaneous hyperæsthesia.

*Chorea*, especially in girls who are neuralgic and hypersensitive. The neuralgic pains are fugitive, pass quickly from one part to another, are readily produced by pressure, and, when not so produced, made much worse by pressure.

*Convulsions*, when the sensorium is non-participative—even in epileptiform spasms there is no unconsciousness.

*Pertussis*, or spasmodic coughs, when the paroxysms are long, face remaining almost pale, although the child fairly bites at air for breath, and cause tears to stream from the eyes. Pain in upper chest, especially under the sternum, when coughing, and after slight expectoration of mucus leaving a sore spot, with burning, as if something had been torn away.

*Asthma* of the spasmodic variety, especially induced from indulging in food that deranges the stomach, and particularly the intestinal digestion. Breathing is very difficult; respirations are loud, short, with occasional interruptions. Sensation as if the sternum lies too close to the back, and so embarrasses the breathing, and causes anxiety and sweat.

In respiratory affections it may be remarked that there is little catarrh, little inflammation, but much nervous excitement, involving the whole cerebro-spinal system.

*Gastralgia* and *enteralgia*, especially when there is much epigastric pain and qualmsiness on awaking in the morning, before meals, relieved by taking food, and, soon after eating, canine hunger. Much flatulent colic without diarrhœa. Pinching and cutting in umbilical region. Mouth is dry; there is thirst, but inability to swallow well, and audible gurgling present when swallowing fluids. Face is very pale, and there is so much itching of the nose that boring with the finger until it bleeds and grinding of the teeth are frequent symptoms.

*Enuresis*, especially in nervous boys who have studied too hard or done too much reading, and who may masturbate from itching of genitalia.

*Amenorrhœa* in young girls who are prone to read much, suffer with asthenopia, have dark rings under eyes, eat sweets

enough to derange digestion, and may masturbate from itching at anus and vulva.

*Fevers* include scarlatina, intermittent and remittent. The face is pale—even so in scarlet fever. Dark rings encircle the eyes; pupils are dilated. Convulsions may be present, and patients constantly grind teeth, bore in nose, are restless, and during sleep frequently cry out aloud, as if affrighted. In intermittent forms of fever vomiting is often present; there is canine hunger after vomiting, and hunger again shortly after taking food; thirst during chill, which recurs daily at same hour.

In conclusion, I may remark that after *aconite* in nervous phenomena accompanying colds, after *digitalis* and *belladonna* in asthenopia, after *drosera* and *antimonium tartaricum* in respiratory affections, after *antimonium crudum* and *cuprum* in gastric and intestinal derangements, *cina* should always be considered, if medicinal treatment is necessary after these drugs have been used.

---

### BROMOFORM.

BY FRITZ C. ASKENSTEDT, M.D., LOUISVILLE.

(Read before the Falls Cities' Homœopathic Medical Society, October 15, 1897.)

My attention had been called to the use of bromoform in the treatment of whooping-cough, the smallness of the dose and the alleged rapidity of effect suggesting the homœopathicity of the drug. So far as I know no proving of bromoform had yet been made, and since bromium has a recognized specific action upon the respiratory passages, I decided to begin a proving of bromoform upon myself. Although almost negative in result, a record of the proving may be of interest, at least from the point of dosage. At the time my age was 27; weight, about 145 pounds; general health, good.

December 3, 1891, at 9.30 A.M., I took internally 25 drops of bromoform in some water; at 11 A.M., 35 drops; at 2 P.M., 50 drops; at 9 P.M., 75 drops. Until 11 A.M., December 3d, no symptoms had been produced. December 4th, 8.45 A.M., I took 80 drops in a little alcohol and water; at 12.45 P.M., 100

drops in water. On that day I felt sleepy all the day, which I could not account for from any other cause than the bromoform. There was also a constant nausea, making even the thought of bromoform intolerable. Dyspepsia, with pyrosis. Tongue slightly coated white, particularly at base. Dull, frontal headache.

December 5th, at 10 A.M., I injected about 5 drops of bromoform, with a little water, hypodermically, into the left leg, as its nauseating effect was already too great for oral administration. (The injection excited no pain.)

December 6th. A crop of small papular eruptions broke out on forehead and face, lasting a few days and leaving, for a time, red maculæ. No itching. The drug was here discontinued, and after some days all symptoms had disappeared. I regret that my aversion to bromoform became so great that no respiratory symptoms had time to develop.

In an article in the *Chicago Medical Recorder*, February, 1892, Dr. E. J. Mellish reports a series of 70 cases of whooping-cough treated with bromoform, 4 of which ended fatally, and 4 others were lost sight of, while the remaining 62 cases, with an average time of sickness of 16 days preceding the administration of bromoform, recovered in average 21 days after the beginning of the treatment. As this gives an average course of 37 days, while the average course without treatment is about 70 days, it is my opinion that when the use of bromoform has become well-defined by repeated provings, we shall have in this drug a leading remedy in our homœopathic materia medica for one of the most obstinate diseases of children—pertussis.

---

THE INFLUENCE OF ALCOHOLISM OF THE FATHER UPON THE VITALITY OF THE CHILD.—Anthony reports a case of a healthy, robust woman, married in her seventeenth year to a notorious drunkard, who, during nine years of married life, gave birth to five small, poorly-nourished children; four of these died ten days after labor from lack of vitality, and one, with every care, lived to be only four years old. Afterwards this woman had a separation from her husband and married a healthy man, to whom she bore two children; the oldest is now four years old and the picture of remarkable health; the second is fourteen days old, and is equally strong and healthy. As syphilis is absent, he believes the mortality of the children of the first marriage to be due to the alcoholism of the father.—*Centralblatt für Gynäkologie*, No. 40.



## THE OPERATIVE TREATMENT OF WANDERING SPLEEN.

BY WALTER STRONG, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Scranton, 1897.)

THE surgery of the spleen could, until very recently, be described as being limited to a single operation, that of extirpation or splenectomy, first attempted in 1826 (Quittenbaum), first performed successfully in 1867 (Pean). Since then this operation has been extensively performed for a variety of pathological conditions of the spleen, as well as for cases of movable or wandering spleen. But with a mortality-rate of 30 to 50 per cent., due to shock and hæmorrhage, splenectomy has never become a very popular operation, except in extreme conditions.

Recently an attempt has been made by some of the continental surgeons to introduce a more conservative operation for cases of wandering spleen. At the Twenty-fourth Congress of German Surgeons (1895) this subject was fully discussed. Rydygier advocated that wandering spleen should be treated upon the same principle as floating kidney, and described a new operation which he termed splenopexis, in which the spleen is returned to its normal position and retained there by a pocket formed by stitching the parietal peritonæum to the gastro-splenic omentum. He had operated upon one case with a successful result three months after operation. In the discussion which followed, this operation was heartily approved of by most of the surgeons present, but in the absence of more clinical reports of the operation no definite opinion could be formed as to the ultimate results.

Plucker, in an article upon splenopexis, says that splenectomy for a wandering spleen is as irrational as nephrectomy for a floating kidney. He also claims that an enlarged wandering spleen is reduced in size by the operation. Sykoff approves of the operation, and predicts a brilliant future for splenopexis. He also favors resection of the spleen instead of splenectomy.

Bardenheurs has recently reported a case of wandering spleen

in which he anchored the spleen in the tissues outside of the peritonæum, and stitched the parietal peritonæum to the peritoneal coat of the pedicle, and secured a favorable result. Some surgeons (Keen) have expressed doubts regarding the permanency of the results obtained, but this is a question which time and the reports of more operations can alone decide.

In these days it requires considerable courage to write a paper upon any operation without being able to also give a long table of operations, and an attempt to report a single operation is liable to be looked upon as an unwarranted intrusion upon the time of the Society. But in view of the fact that it is only a little over eighteen months since this operation was first suggested, and bearing in mind that so few operations are upon record, I feel that I may be pardoned for bringing to your notice a single case of wandering spleen treated by splenopexis (splenorrhaphy?).

Mrs. L.; married; aged 33 years; admitted to Women's Homœopathic Hospital on October 13, 1896. Patient born in Italy (central) but has been in this country for over eight years. Has had five children, three of which are still living, last child about ten months ago. Has always enjoyed good health, and no history of ever having had malaria. Patient is well nourished, rather stout, and has large abdomen. Ten days ago fell down stairs and struck upon a bucket, striking left hypochondrium; since then has been confined to her bed and treated by a neighboring physician, but without any relief.

Upon admission complains of intense sharp, continuous pains in the left side of abdomen, extending upwards, and aggravated by motion, pressure, or breathing. Much distress upon taking food, and some vomiting. Bowels loose and watery, much pain with bowel movements. Burning during micturition. Unable to sleep at night on account of pains in side. Temperature, 99.4°; pulse, 96; respiration, 28.

Examination reveals a large, sensitive mass upon the left side of the abdomen, extending from under the left ribs downwards to point two inches below level of umbilicus, and extending from a line one inch to the right of median line well over into left flank. Lump is very sensitive to touch, and more or less freely movable. Some distention of entire abdomen, increased rigidity of the left rectus muscle. Examination per vaginam

reveals uterus free, laceration of cervix, and no evidence of hæmorrhage in pelvis. Urine negative.

Diagnosis of acute dislocation and contusion of spleen was arrived at, partially from the above symptoms and conditions, as well as by exclusion. Patient was put to bed, with a firm compress over the abdomen to keep the spleen from moving, and put upon liquid diet. Symptoms gradually improved, pain decreased, vomiting ceased, and in every way patient's general condition improved. Remedies employed were aconite, arnica, rhus tox. Patient sat up and walked about with very little discomfort; finally, upon October 28th, patient felt so well that she insisted upon going home.

November 3d patient returned to hospital and asked to be readmitted, as she was totally unable to get along with her work at home.

Patient admitted November 3d. Abdomen still sensitive; tumor is somewhat smaller, is further down in abdomen, and more freely movable. Not so much pain or distress if patient remains quiet, but so soon as she moves about the pain and distress become severe. Temperature, 99.2°; pulse, 100; respiration, 34.

The case was treated by rest in bed, compress over abdomen, liquid diet and internal medication until November 18th, without any apparent relief; the temperature, pulse and respiration remained about the same, more or less constant vomiting, troublesome cough and much pain in abdomen, which is burning and drawing in character. The patient now consented to an operation, splenopexis or splenectomy, as I saw fit after opening the abdomen. Consequently was prepared for abdominal section after the routine plan.

November 19th. Patient etherized, incision made at outer border of the left rectus muscle from the ribs downwards to crest of ilium. Upon opening the abdominal cavity the tumor presented itself; from its contour and color was easily recognized as being an enlarged and displaced spleen. Spleen enlarged considerably, freely movable in all directions, no adhesions, no evidence of hæmorrhage in the region of spleen. Other organs excepting the left kidney apparently normal; left kidney was somewhat enlarged and boggy. I determined, if possible, to save patient the dangers of a splenectomy and endeavor to



stitch the spleen in place. With the object of getting adhesions between the spleen and parietal peritoneum I freely scarified the peritoneum over the normal situation of the spleen, then pushed the spleen into its proper location, and by means of several interrupted silk sutures stitched the gastro-splenic omentum to the parietal peritoneum, carefully avoiding the vessels, and also being very careful not to make traction upon the pedicle, for whenever the least traction was made upon the pedicle most alarming symptoms of collapse ensued. Washed out with neutral salt solution, sutured the peritoneum with silk and the remainder of the tissues with silkworm-gut, applied aseptic dressing and a snug binder. Time of operation, 35 minutes. Amount of ether used, four ounces.

Following the operation there was very little shock, reaction came on very promptly, there was no vomiting, passed flatus in twenty hours, was allowed water in small quantities five hours after operation, and took some nourishment (malted milk) ten hours after operation. At no time after operation did the temperature exceed 100.3°. Was re-dressed upon the sixth day; found wound perfectly dry and healing by first intention. Upon the tenth day the sutures were removed, with wound perfectly healed. Kept the patient in bed until December 19th when she was allowed to sit up, and patient was discharged December 31st.

Condition upon discharge; wound entirely dry and not sensitive, the spleen in place and not movable, some slight sensitiveness upon deep pressure. Patient feels perfectly well in every respect. Advised patient to wear an ordinary elastic support for abdomen.

When I last saw the patient (June) she was enjoying excellent health, attending to her usual household affairs; at times slight pain in region of spleen. Spleen decreasing in size, not movable, and only sensitive on deep pressure. For the history of the case and accompanying records I am indebted to our house surgeon, Dr. Russell.

From my experience with this one case I do not hesitate to say that for wandering spleen splenectomy is no longer a justifiable operation, unless the spleen is so much enlarged that it could not be retained in place. Were I to meet with a case in which it was impossible to stitch the gastro-splenic omentum to

the parietal peritoneum in such a way as to retain the spleen in place, I would not hesitate to anchor the spleen in the tissues outside of the peritoneum. Besides the dangers which are always connected with a cœlotomy I do not consider the operation one of any special risk. It is, I think, an operation which should be advised in all cases of wandering spleen which are not amenable to treatment by an external support, and also an operation which should always be kept in mind in connection with abdominal operations, inasmuch as not a few of our most experienced surgeons have mistaken an enlarged displaced spleen for other conditions, and in not a few of these cases splenectomy has been resorted to with fatal results. As to the permanent results of this operation, is there any rational reason why the results of splenorraphy should not equal those of nephrorraphy?

---

HÆMORRHAGES IN THE CEREBRO-SPINAL CANAL IN THE NEW-BORN.--(Schaeffer). Hæmorrhages from the vertebral canal of the new-born occur once in ten sections, and cerebral extravasations occur twice in 10 sections. In 17 cases of hæmorrhage of the vertebral canal there were 40 per cent. in operative births, where the operation itself was the cause of the hæmorrhage. There were 5 mature children delivered—two by forceps in vertex positions, two extractions of the breech, and two extractions of the breech in premature children. The children died in labor, or within several hours or days after.

In 24 per. cent. of other lesions of labor there were two mature children died from injury to the brain in vertex positions, one mature child by direct laceration of the cerebral vessels, one mature child from injury to the heart and circulation in the delivery of an after-coming head. About 64 per cent. died from lesions originating in labor.

Locally and etiologically hæmorrhages were divided as follows:

a. Three times at the medulla oblongata, accompanied with asphyxia, operative delivery and maturity of the child.

b. Hæmorrhages in the cervical portion; extraction by the Mauriceau-Veit method.

c. Three times in the cervico-dorsal and dorsal portion; breech extraction.

d. Twice in the dorso-lumbar portion, with diffuse or extensive hæmorrhages, partly due to lesions of the brain and partly due to diseases acquired post-partum.

The prognosis in hæmorrhages of the medulla oblongata is unfavorable; otherwise, it depends upon the extent of the hæmorrhage and the compression of the spinal cord, and particularly on the original cause of the injury. In asphyxia and immaturity of the child, any severe mechanical effort, especially breech extraction, or even Schultze's method of artificial respiration, or unskilful manipulation, may cause such hæmorrhages.

## EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

## NEW YEAR'S RESOLUTIONS.

FOR the "natural man" there is no appreciable difference between the thirty-first of December and the first of January, but to the "spiritual man" the ringing of bells, the shrieking of whistles, the tooting of horns, the cracking shots of New Year shooters, and the hundred other like discordant sounds that usher in the New Year are symbolic of much. They seem to him like a Wagner-esque descriptive overture to a new scene in the drama of life, while the tolling of the midnight hour rings up the curtain.

He knows that the program is fixed, the parts assigned, the action decided, the denouement certain, and yet it is with curiosity as to these, not unmingled with awe, that he takes up his own seeming improvization and begins to act his part. Even between the covers of a medical journal, unsuspected, perhaps, and almost buried beneath the weight of the impersonal editorial "We," there lurks a semblance of a conscience which compels to the forming of good resolutions, despite a knowledge of the base use for which these are proverbially destined. Its conscience is, fortunately, no two-sided, Janus-like affair. It does not reproach with imperfections and derelictions, but only prompts to higher attainments. It knows no useless remorse for past errors, but only resolves to commit none in the future. The curtain has been rung down on the last act, and it must now only see to act well its part in the new one to come.

What is the part assigned to this journal in the medical play which is being presented? Whether this play be comedy or tragedy we wot not. When we see the shifting scenes, the dazzling lights, the rapid transformations, the tawdry and scanty costumes, we think we have a comedy, and no divine one either; but when we turn to the disappointed hopes, the shattered idols, the vain conflicts, the fierce jealousies, the bla-



tant ignorance and irrational prejudices—it is a veritable tragedy.

The only clue to the intricacies of this masque is the ever-present seeking after the truth. This quest is the ruling motive of the play, and from this the journal must take its cue.

Although a journal devoted to homœopathy, its duty to present whatever view of the truth it may possess must ever be paramount. We recognize that the present is a period fraught with no mean danger to homœopathy. A reaction has set in against the extreme views and unlimited claims naturally engendered by the circumstances which surrounded its origin, and the danger is immanent that the reaction may go too far. Already have the taunts and jeers of a falsely so-called “scientific medicine” driven many within our own ranks to an equally false assumption of science, to the great detriment of individual progress and of the profession at large.

Again, the *sometimes* well-meant flatterings and cajolings of the old school have tempted many to cherish the vain hope of a speedy union of the two schools, ignoring the fact that such union could only be accomplished by a surrender of the fundamental principle of homœopathy.

Timeo Danaos, et dona ferentes.

The olive branch held out bears only Dead Sea fruit.

Again, in our desire to educate the on-coming physicians up to the standard set by our opponents, we have done so too much on their own lines, and not on independent ones, worthy of homœopathy as a science. We have allowed ourselves to be dictated to, indirectly it is true, but none the less surely, as to what must be considered essential to a well-qualified physician. The overweening importance attached to diagnosis and pathology in their work has been reflected in our own, and we have too unhesitatingly followed their lead in widening the sphere of so-called surgical diseases.

Finally, the character of homœopathic literature has changed, in some respects, undoubtedly, for the better. Compare the journals published twenty years ago with those sent forth at the present time. Then the cases reported were purely medical, given with conscientious detail of subjective symptoms and modalities, with the key-notes which led to the selection of the

remedy which removed them. Perhaps a name was given to the complex of symptoms; more frequently not. Objective symptoms and the results of physical examination were conspicuous by their absence. All was relieving of symptoms, called cure. Such literature could not long satisfy the awakened medical conscience, and resort was had to allopathic journals, where the tendency was all the other way. There the difficulty was to find even a hint as to the treatment, the result of which was usually regarded as of secondary interest. Our own literature then changed, but, unfortunately, too much in imitation of the other. Occasionally we find papers wherein all the demands of a scientific diagnosis and pathology are answered, together with the presentation of an equally scientific choice of a homœopathic remedy—but such papers are, alas! but rare. The liberality, both mental and pecuniary, of homœopaths in buying books and subscribing to journals of the old school is well known, and, in a measure, commendable, but is not conducive to the best interests of homœopathy. For experienced physicians such reading should not be capable of producing any bad results, but for students and young graduates it cannot but result in mental malnutrition. Errors in diet are now universally regarded as the contributing cause of a majority of the diseases of childhood. On such mental pabulum can we wonder that there are so many rickety and deformed homœopaths?

These seem to be the most immanent dangers to homœopathy, a borrowed *quasi* scientific therapeutic method, a sentimental cry for peace where there can be no honorable peace, college curricula padded and fashioned according to a foreign type, and an unhealthy appetite for artificial nourishment; and against these this journal will continue to oppose whatever of influence and power it may possess.

In the old school the running hither and thither after new remedies and specifics, and their application to all cases indiscriminately without attempt at individualization, is a natural and logical outcome of its unregulated empiricism, but in our school it is both illogical and disloyal. While this journal has not failed to keep trace of the boasted advances made in various directions in their therapeutics, and has willingly allowed them to have the much-desired but empty honor of priority

in experimentation, it has always maintained that homœopaths should remain true to their principle and methods in adopting any of them. Their misdirected efforts at cure have often given us "provings" which have proved of service.

We have at various times pointed out that the difference between the schools is a radical one, and that the gulf which separates them cannot be bridged by the granules of the one and the larger doses of the other. A basis of union can only be found when both sides have learned the true meaning of the word "cure," and when we homœopaths have scientifically grounded the significance of our "similibus," the similarity upon which alone the hope of a cure can be predicated. In the meanwhile, to a cessation of hostilities, an armistice, to enable both sides to bury their dead, this journal might consent, but to a peace conditioned upon the surrender of our standard—never.

While we have not been as loud, perhaps, as some of our contemporaries in denunciations of the medical legislation fad which runs riot in the land at present, our views on the uncalled-for and illogical trend of the various medical examiners' bills are well known to our readers. The direct consequence of these has been the altering of the curricula of our colleges to correspond with the demands of our enemies.

No one is more willing to recognize the immense good that has resulted from this enlargement of the curricula, viewed from the standpoint of general medical education; but when called upon to decide the question of the benefit to homœopathy and its development by exactly such changes, we hesitate. There can be no doubt that through the State medical examinations the homœopathic graduates, who have passed them, stand before the law and the public as the peers, in medical knowledge, of their colleagues of the school hitherto known as the "regular," and we believe they are. Hereby, no doubt, the name of homœopathy has been elevated, and its adoption by a larger clientele furthered,—but has there been a corresponding inner growth? Has this widened scientific knowledge, on the part of its students, been devoted to the establishing more firmly the foundation of homœopathy and developing its principle? We sadly confess that the evidences of this are not marked. We recognize such efforts on the part of older physicians to whom experience has brought a realization of the



value of such knowledge, which was not within their reach when students; but among the majority of the younger members of the profession a condescending tolerance of homœopathy, as in some case of some benefit, has taken the place of the just as illogical and unfortunate faith in its universal applicability of thirty years ago. Had we the faith and enthusiasm of those times, coupled with the science of the present, homœopathy would be invincible. These are not incompatible. If homœopathy be true at all, it must be willing and able to stand the investigation of science, or vanish. A "higher criticism" is here, even more than in theology, demanded by the spirit of the age. Incalculable injury has been done to the advancement of homœopathy by the unreasoning adoration (we can think of no other word) of Hahnemann and his every word. A reaction was sure to come, and in its coming it has too often, alas! brought with it a belittling of his attainments, and his writings, while still considered by some as almost inspired, are by others set down as the vagaries of an enthusiast. No better work has been done in counteracting this latter tendency than by Bradford, in presenting a life of Hahnemann in which is brought out all that he really was. The author has given us in it a "proving" of Hahnemann, that bitter pill which the old school has been so long attempting to annihilate because it could not swallow. In the light of his life, Hahnemannianism and its relation to homœopathy become intelligible. Let this relation be brought out in our colleges; let the students be shown what homœopathy is, and what Hahnemann thought of it, and how he came to think as he did. They will then be in a better condition to attempt to separate the wheat from the chaff, and to recognize the limits of their allowable criticism—and perhaps learn modesty. The immediate results of the knife, of the hypodermic and antitoxin syringes, are so much more dazzling than those reached with far more mental effort by attempted homœopathic treatment, that it is no wonder that in this spectacular age the young graduate is blinded.

Finally must not be disregarded the part this journal is called upon to play in acting as caterer to the dietetic needs of the profession. Let it be understood that the expressed or implied wants of the profession are a most important factor in making a journal what it is. By its presentation of extracts

from homœopathic journals, whose scope and aim seem to be slightly different from its own, and by its gleanings from allopathic sources, selected with care and intelligently condensed, it has striven to keep its readers abreast of medical progress in a practical way. In the matter of original contributions, the task—not of filling the pages, but of selecting from the mass offered without giving offence—is a more difficult one than can be imagined by the uninitiated. Only by seeking to impress a certain individuality upon the journal can it hope to prevent the offering of MSS. which self-preservation would compel it to reject if offered, and only in so far can it attempt to realize its own ideal of a journal. It seeks to be a liberal journal, but always a homœopathic one, and especially welcomes all contributions which tend to develop the system in line with the present teachings of science. But its age and experience make it also a conservative one, never abandoning a good thing until a better one has been found; testing all things, but holding fast to the best.

Now let the curtain rise and the play begin.

---

#### THERE IS NOTHING HIDDEN BUT WHICH SHALL BE REVEALED.

SINCE the Denver meeting of the American Institute of Homœopathy, for reasons and motives not yet perfectly clear, but which will come to light in good season, a number of members not old in attendance have been increasingly clamorous that the young member is not in sufficient evidence in the councils and offices of the Institute, notwithstanding that at Denver, Newport and Buffalo he was almost offensively so.

This line of attack not being quite sufficient to convince those who attend the meetings that black is white, they have gone a step farther, and under various pretexts have assailed the dignity, solidity and perpetuity of the Institute, and assert that the deference and confidence reposed by the majority in the active senior members has spoiled the opportunity and curtailed the usefulness of the younger element, and as a consequence the Institute is afflicted with dry rot or senile decay, leading to dwindling attendance and lack of interest. They have also indulged in much more that is unkind, but as it is not germane to the issue it will be unnecessary to note.

Omitting needless details, the complaint or criticism seems to resolve itself into four propositions: *a.* That the young members of the Institute are ignored. *b.* That the seniors are false or recreant to their trust, inasmuch as they have gathered every preferment to themselves. *c.* That the meetings are poorly attended; and, *d.* That the interest of the members in general is on the wane.

We are confident that any member who has attended the last ten meetings of the Institute, who is familiar with the records, and who is free from personal bias or prejudice, having solely at heart the interests of the Institute, and not that of himself or his close personal friend, will give an emphatic denial to all four propositions.

But it is plain that there is some hidden difficulty which has given rise to this manifest spirit of unrest, and when it is revealed, if the fault can be honestly laid at the Institute's door, it will be handled with vigor in the line of correction until the most relentless of critics is satisfied, for the spirit of the Institute is that of fairness to all.

The cry that has gone abroad that the young man has no opportunity for work seems strange, for there is plenty of work, and the workers are few. "Work wanted" is probably a masquerade for "prominence wanted." If this is correct, the difficulty is revealed and the remedy is at hand—self-restraint, with a knowledge that all things come to him who waits, will be sufficient to eradicate the evil.

We can sympathize with ambition, even if it overleaps itself, for it is human, and we have no objections to anyone reaping prominence, provided they have sown the seed and nurtured the growth that legitimately evolves prominence, and we admit that ripening maturity comes to members in unequal lengths of time according as it may be controlled or governed by the combination ability and opportunity. But the test of fitness for the possession of the flesh-pots of office must be character, capability and capital—capital being knowledge of the organic life of the Institute, together with its present-day purposes and necessities. Without such acquaintance it would be folly to advance anyone to an office of prominence or responsibility, whether he be a member of five or fifty years' standing.

It is certainly an outrage to the self-respect and an insult to the intelligence of the Institute, with its great number of mem-



bers from all sections of the country who are fitted for the presidency by long years of faithful service and pre-eminent medical attainments, to bring forward as a candidate for its executive office a member who has attended but four or five meetings. No matter how great his individual ability and worth may be, he is not fitted for the responsible position, and it is useless to deceive ourselves or to confer our honors so cheaply. If such a one permits the use of his name, his indiscretion stamps at once his unfitness; but as the temptation is great to accept an office carrying with it the highest honor in the gift of the profession, the judgment passed upon the yielding should be tempered with mercy. For what profit is there in gaining the presidency at the loss of the respect of the Institute?

We are thoroughly in touch and sympathy with the young members, and are firm believers in the just recognition of their merits and deserts, and in this we feel we are at one with the majority—yes, with the entire membership of the Institute, with a possible exception of half a dozen seniors. These poor, misguided wretches are the victims of indigestion, gout or marital mishaps, which have spoiled otherwise amiable dispositions and curdled the milk of their individuality. Even with these few cases the young, oppressed members should possess their souls with the grace of Christian charity, and bear with their elders, lest otherwise they become like unto them.

Are the younger members of the Institute ignored? Well, take down haphazard two or three volumes of the *Transactions* for the last ten years, and scan carefully the list of officers and the membership of the standing and special committees and of the various sections, and then answer for yourself. There is no excuse for being misled, for silent, convincing testimony is right at hand, and whatever the individual grievance may be, the young member, as a class, has not been ignored.

The chief end of Institute membership is not position and office, and an active member of five years' attendance should not expect to have the same confidence and trust reposed in him as is freely given to the tried veteran of thirty or more annual meetings. If there is to be any coddling in the Institute, it will be well to spoil a senior, for the good have died young, and a senior's expectancy being shorter than a junior's, the thing evil will be sooner removed to the great relief of the Institute. Then, too, the experience will be valuable to the

young member, and when he reaches that delectable period of Institute star-chamber life he will be well prepared to receive the tender, considerate, merciful indulgence of future generations of Institute young members.

There is something yet to reveal, for the young member is not ignored, so this is not the cause of the restless discontent. Are the seniors false or disloyal to the trust reposed in them? We think not. The wisdom of their counsel and direction has developed the Institute to a mighty power, and their splendid achievement is a monument to their integrity and uprightness of purpose. Have their methods been open to criticism? Certainly; whose have not? They are to be judged by the results of their work, and it is good. Of course, some of the seniors are stupid, tiresome people, and it would be to the advantage of all should they remain at home. Candor bids us say the same of a larger number of the younger members; so we can afford to call this score even. If there is a senior who has foolishly accepted seven committee appointments, as one of the Institute critics claims, and he has attended to his various duties in a manner commensurate with the responsibility pertaining thereto, praise, rather than censure, should be his meed, and friends should whisper into the ear of this faithful pack-horse that his unselfish devotion to the Institute's cause is unnecessary, and should persuade him that his duty to himself, his family and to his profession demands that he should unburden and shift part of his pack to other shoulders. He will undoubtedly yield gracefully when things are made plain to him. Criticism is easier than service. The attack upon the seniors comes from a few, and arises probably from an improper understanding of motives. The sentiment of the Institute is certainly that of appreciation and respect for its senate of seniors.

Are the annual meetings poorly attended? They certainly are not. A 10 per cent. attendance of a national organization which is not a delegate body is a large attendance in times of peace and prosperity, and a much smaller percentage is good in times of stress at places of meeting far removed from the majority of the members; and yet the Institute's attendance has ranged above 20 per cent. of its entire membership. These facts are clearly shown in a characteristically vigorous editorial in the *North American Journal of Homœopa-*

thy for November, 1897, by Dr. Eugene H. Porter, the Secretary of the American Institute :

“A careful study of the Institute records shows that from 1885 to 1890, inclusive, the average attendance at the Institute meetings was 185. From 1891 to 1897, inclusive, the average attendance has been 432. From 1885 to 1890, inclusive, the average number of new members yearly was 82. From 1891 to 1897, inclusive, the average number has been 157. These figures give the cold facts, and are unanswerable.”

There are many things governing attendance upon meetings. The nearness or remoteness of the place of meeting from the homes of the members. The conditions governing the country, etc., have a decided weight, an era of prosperity having a marked bearing. A too frequent return to the same section is a disadvantage; for instance, the Detroit and Buffalo meetings were too close together.

If the '97 meeting had been held near Philadelphia, the members present would have equalled or gone beyond the 494 of 1891 at Atlantic City; but it would have been unfair to have expected the same number at Buffalo or Denver with so few local physicians to draw upon.

Is the interest of the members upon the wane? There was no evidence of such being the case at Buffalo or at any recent meeting. It may be in individual cases from one or another cause. This is unfortunate, and the members should all get together and ventilate, in the spirit of fairness, the difficulties, with the end in view of ascertaining the real cause and removing the same. This will be far better than standing off and throwing stones into our own glass-house. If the motive is honorable and is held tolerantly there will be no insurmountable difficulty, for way down in the inmost heart of every member there is nothing but good for the Institute.

The time has come to speak with unmistakable plainness. The Institute has nothing to hide; everything is open and above-board; error and mistakes are more than possible, and occur frequently. But error can never long prevail, and the Institute has always wisely corrected it whenever made apparent. And when its present harsh critics come out into the open and reveal all that is hidden, the Institute will be quick to grasp the wrong and right it to the satisfaction of all fair-minded members, be they young or old.



## GLEANINGS.

---

THE PATHOLOGY OF ACROMEGALY.—A recent meeting of the Pathologica Society of London was devoted to the discussion of acromegaly. Mr. Furnival stated that in every one of the thirty-four examples that he had collected there was some affection of the pituitary body, thus bearing out the original observation of Marie. At the present state of our knowledge, however, it is difficult to arrive at a conclusion respecting the relationship existing between the skeletal changes and the somewhat heterogeneous character of the lesions in the pituitary gland. In no inconsiderable proportion, too, the thyroid body was also affected. Dr. Rolleston drew attention to the fact that in the more rapidly advancing cases of acromegaly the pituitary disease was sarcomatous, a fact pointed out by Sternberg. The latter, in his recent monograph, distinguishes three types: the benign, which may last for fifty years and lead to but slight discomfort; the ordinary chronic acromegaly, lasting from eight to thirty years; and the acute malignant type, of from three to four years' duration. In speaking of its pathogeny, Sternberg says that there are many theories current, and collates them under the heads of: (1) the nervous theory, held by von Realdinghausen and others, but now mostly discarded, that observer's case being recognized as syringomyelia; (2) the theory of atavistic perversion of growth, as suggested by Freund and Campbell; (3) the thymus theory of Klebs; and (4) the pituitary theory of Marie, who contrasted the disease with myxedema or cachexia strumipriva. Dr. Dalton, at the above meeting, advanced another theory, namely, that there was a tendency to general tissue hypertrophy, illustrated in his case by evidences of connective tissue hyperplasia, hypertrophy of the cutaneous papillary body, as well as of the viscera. That disease of the pituitary body may occur without any of the characteristic changes of acromegaly being present was pointed out by more than one speaker; but, as Mr. Butlin pointed out, it would be well in the future for those who met with such cases to be careful not to overlook any concomitant changes that might suggest acromegaly. Dr. Payne's remark that cases of acromegaly in its incipient stages must occur, although they pass unrecognized, is worth noting in this connection.—*Lancet*, November 6, 1897.

THE NERVES OF THE HEART AND THE THYROID GLAND.—M. E. de Lyon, of the French Academy of Sciences, has just discovered the physiological destination of the third branch of the depressor nerve which forms an anastomosis with the superior cervical ganglion, also with another branch of the same nerve coming from the superior laryngeal.

1. Excitation of this third branch causes a diminution of arterial pressure, very often accompanied with an acceleration of cardiac pulsation, especially if the two pneumogastrics have been previously divided. At the same time a slight but persistent contraction of the pupils is produced.

2. The branch which proceeds from the superior laryngeal—the largest in

the rabbit—serves to put the heart in direct communication with the thyroid gland, and causes the heart to intervene in the function of this gland. The cardiac filaments of the inferior laryngeal nerve have probably the same destination, physiologically.

3. The iodothyrene of Baumann, when introduced into the circulation of the blood, exercises a pronounced action upon the nerves of the heart and the vessels, and particularly upon the function of the depressors. In certain phases of this action the excitation of the depressor nerve sometimes provokes so strong a blood-pressure that the animal succumbs because of the inability of the heart to recover from the pressure.

These new researches demonstrate the existence in the depressor nerve, besides the well-known centripetal nerve fibres, of others capable of reflex action upon the accelerator nerves, and the oculo-motor apparatus, and directly upon the thyroid gland. This diversity of functions of the depressor nerve, and also the reciprocal influence that the heart and the thyroid gland can exercise upon each other by the intermediation of this nerve, permits an explanation of the principal symptoms of Basedow's disease, the goitre, exophthalmia, cardiac symptoms and persistent diarrhœa—the latter from paralysis of the splanchnic nerves, by the different actions exercised by the depressor upon the great sympathetic.—*N. Y. Medical Times.*

HEMIATROPHY OF THE TONGUE.—Dr. Harold N. Moyer, Chicago, reports the following case: A young man aged twenty-five years received a wound in the left cheek from a 32-calibre revolver, November 22, 1892. The bullet was located in the bone, but no attempt was made to remove it. Immediately after the accident the jaws were firmly locked together, but at the end of three weeks, with the healing of the wound, this began to subside. During this time his voice was very weak and articulation imperfect. As these symptoms improved he noticed that he could not manage food as well on the left side of his mouth as on the right. It collected between the teeth and lips or adhered to the roof of the mouth; it was necessary for him to remove it with a spoon. It was about three months before the mouth could be fully opened. The patient knew of the limited motion, but paid no attention to it until about one year later, at which time he noticed that the left side of the tongue was becoming smaller and seemed to be drawn to one side. He then observed some difficulty in articulation and some salivation, the latter not being marked. Within the last two years there has been an improvement in all these symptoms. The articulation has improved, but he cannot speak rapidly, and if this is attempted the speech becomes unintelligible. Slow articulation is distinct and clear. Taste has been impaired almost from the beginning, and food on the left side of the mouth seems dry and tasteless. Careful testing shows that taste has been abolished on the anterior and posterior surfaces of the left half of the tongue. The tactile sense has been retained. The velum is normal, and the faucial reflex intact. Sensation in the face is normal. Sense of smell is the same on both sides and normal. Jaw reflex normal.—*New York Medical Journal.*

F. MORTIMER LAWRENCE, M.D.

THERAPEUTIC HINTS.—Dr. Samuel J. Smith, Filley, Neb., in the *Eclectic Medical Journal*, November, 1897, gives a long list of therapeutic hints, of which the following are abstracts:

*Acidum Boricum*.—R. Boracic acid one drachm, borax one drachm, salt half a drachm, listerine two ounces, water six ounces. Mix. An excellent cleansing and disinfecting solution for use in the nasal cavities. R. Acid boracic half-ounce, tincture hyoseyamus half-ounce, syrup simplex one ounce, camphor water six ounces. Mix. Dose, one teaspoonful three times a day. For frequent desire to urinate. R. Boracic acid six drachms, glycerin six drachms, rose water twelve ounces. Mix. A preventive and cure for sunburn. R. Boracic acid grains fifteen, water one ounce. Mix. Apply three times a day for stytes.

*Acidum Salicylicum*.—R. Acid salicylic one drachm, alcohol three ounces. Mix. Applications of this will cause pimples and comedones to disappear. R. Salicylic acid six drachms, boracic acid six ounces. Divide each into twelve powders. One powder of each dissolved in a pint of water makes Thiersch's Solution No. 1, which may be used anywhere except the eye. For the eye double the quantity of water should be used, making Solution No. 2.

*Argenti Nitras*.—Dyspepsia of nervous type; flatulent, belching quantities of gas, making a loud noise. Afraid to attend church, or to be placed in any position where it would be impossible to go to stool. Give one tablet of 6x before each meal. To remove nitrate of silver stains: Dissolve fifteen grains of corrosive sublimate in six ounces of boiled water; add about forty-five grains of salt just before using; lay the material in the solution for five minutes, then wash two or three times.

*Cumphora*.—Gum camphor one-half ounce, spts. turpentine three ounces. Mix. Apply to the breasts to check secretion of milk.

*Chrysarobin*.—R. Chrysarobin one and one-fourth grains, iodoform five grains, ext. belladonna one-sixth grain, cocoa butter thirty grains. Mix. If there be much bleeding, add tannin. Introduce one, two or three times a day in internal piles. In external piles apply the following: R. Chrysarobin twelve grains, iodoform five grains, ext. belladonna nine grains, petroleum four drachms. Mix.

*Eupatorium Aromaticum*.—R. Fluid ext. eupatorium, fluid ext. hydrastis, each two drachms, water three and one-half ounces. Mix. One teaspoonful every hour in nursing sore mouth.

WOODWARD D. CARTER, M.D.

**TYPHO-MALARIAL FEVER**.—Dr. Charles H. Harris, of Cedartown, Ga., insists that the so-called typho-malarial fever of his region is neither typhoid nor malaria, nor a combination of both, but a distinct disease. He presents the following differentiation:

*Typhoid*.—Several days' malaise and prodromes; first day's temperature, 99°; pulse, 100; headache; mind dull; surface uniformly warm; tympanites; iliac tenderness and gurgling; diarrhœa; tongue has white fur, and trembling; subsultus tendinum; delirium; intestinal hæmorrhage late and in convalescence; nose-bleed; urine has traces of albumin; no specific; course and duration typical; cannot be aborted.

*Atypical*.—Accession abrupt; no prodromes or chill; first day's temperature, 102° to 105°; pulse, 120; mind clear to last; extremities cold, abdomen hot; no tympanites, iliac tenderness or gurgling; constipation; tongue changed but little; no trembling; yellow fur; no subsultus or nose bleed;



intestinal hæmorrhage as early as second week ; no albuminuria ; course and duration atypical ; can be aborted ; opium a specific.

*Malaria*.—Accession abrupt ; chill ; first day's temperature, 103° to 106° ; pulse, 98 to 120 ; periodical ; abdomen turbid ; surface temperature uniform ; no tympanites ; no gurgling ; no iliac tenderness ; thick yellow fur on tongue ; no trembling ; urine scant and yellowish-red ; no albumin ; course and duration subject to treatment ; one attack predisposes to another ; intestinal hæmorrhage rare ; nose-bleed rare ; quinine a specific ; may be intermittent or remittent.—*Medical World*, 1897.

SO-CALLED TYPHO-MALARIAL FEVER.—What is typho-malarial fever?

Is it genuine typhoid or enteric fever?

Is it an atypical typhoid fever?

Is it malarial fever with the typhoid state?

Is it a hybrid combination of malarial fever and typhoid fever?

Is it a continued fever of a different nature from either of the above?

Dr. Joel Crawford, of Yale, Virginia, attempts to answer the above questions. He says: "Were it, strictly speaking, a malarial fever, quinine ought to be a specific in the treatment of the disease, preceded by a dose of calomel, provided time would permit its use. But, on the contrary, the administration of quinine after the first few days of its onset is apt to do more harm than good, while calomel in purgation doses is deadly. For the first few years of my professional career I looked upon it as being malarial fever with the typhoid state, solely because Prof. Alfred Stillé had taught his class to believe it. He says: 'Typho-malarial fever was a name conferred upon typhoid cases of remittent fever by the late Surgeon Woodward. United States Navy, who was a scientist and a clinician.'

"Notwithstanding the fact that some few cases do make their appearance from time to time which present, from a clinical standpoint, the features of both diseases in combination, I now look upon the disease as being a modified, irregular, or atypical form of typhoid, without any malarial admixture.—*Virginia Medical Semi-Monthly*, 1897.

F. WALTER BRIERLY, M.D.

CLINICAL DIAGNOSIS OF SCROFULOSIS.—Hugo Neumann (Berlin) regards scrofulosis as a tuberculosis, though a few of its symptoms may be looked on as parascrofulous. The tonsils are frequently the doors of infection. Symptomatically, the glandular swellings are intermediate in the clinical picture, and among these are the often undervalued and overlooked enlargement of the bronchial glands. This is not easily diagnosed. If there be audible in the interscapular space a greater area of bronchial breathing than is normal, the cervical glands are slightly swollen, and rectal measurements of temperature show a slight febrile movement, then enlargement of the bronchial glands is probable. According to the years he distinguishes three groups: In the first to third years tubercular infection occurs, and grave bone-affections, scrofulo-derma, etc., result ; fourth to eighth years, keratitis interstitialis, etc. ; ninth to fifteenth years, the glandular enlargements, the affections of the mucous membranes, and the eczemas. Prof. Nil Filatow, *Semiotik und Diagnostik der Kinderkrankheiten*, 1892, distinguishes two scrofulous types, the torpid and the erethetic or florid.

In the first the face is swollen and pale, the upper lip thick, the hair blond, the abdomen big, the adipose layer well developed but flabby, with flaccid

skin and muscles. Such children are usually apathetic and unwilling to do anything. They are liable to enlargements of the lymph-glands and local glandular and bone tuberculosis.

The children of the florid type are slender, with silky and mostly dark hair and long eyelashes, dark blue eyes surrounded by a bluish sclerotic. Their subcutaneous connective tissue is very poorly provided with fat, their skin thin, tender, and coursed with many veins, especially on the temples. The long bones are sometimes strikingly delicate, the muscles weakly developed; in short, the organism bears the stamp of the greatest delicacy and weakness. Such children are especially vivacious and nervous, and develop very quickly and early. The superficial lymph-glands enlarge less often than the bronchial. The disposition to chronic local tuberculosis is here less than to acute miliary tuberculosis and tubercular meningitis. These two types have a number of intermediate transition-types.

The most frequent manifestation is hyperplasia of the lymph-glands, especially of the neck, where a chain of glands extends from the lower jaw and along the border of the sterno-cleido-mastoid, which are oval, hard, painless, and of the size of a cedar- to that of a hazel-nut. With cheesy degeneration they attain considerable size and hardness, forming with neighboring glands large, uneven masses, which disfigure the neck.

The skin is often affected with obstinate eczema, impetigo or ecthyma. The eyes may present blepharitis, keratitis, phlyctenosa, and conjunctivitis; the ears, otitis media and externa; the mucous membranes, catarrhs, ozaena, frequent bronchitis, inclination to diarrhoea or constipation; the long bones periostitis, caries of the vertebræ and other smaller bones, especially of the tarsus and fingers, as spina ventosa, as well as diseases of the joints, as chronic synovitis, tumor albus.

A CASE OF THROMBOSIS OF THE FEMORAL VEIN IN CROUPOUS PNEUMONIA.—Dr. J. Katz (Berlin) reports the interesting case of a workman of thirty-six years, who with fair personal and hereditary history, after a croupous pneumonia of moderate severity without associated heart-weakness, on the afternoon of the seventh, the critical day, after typical sweating and defervescence, fell asleep, and suddenly awakened with violent pain in his left leg, which was noticed to be much swollen, so that in the region of the abductors it was three times the size of the opposite one. Its color was cyanotic, and it was markedly cooler than the other. On account of the swelling no thrombus was palpable; sensibility and movement were intact. Besides the sense of cold and tension he felt otherwise well. Nothing abnormal in the heart or kidneys. No fever. With elevation of the limb and rest the œdema gradually receded, so that in three months he was able to resume work. There was no later inclination of the limb to swell.—*Deutsche Medicinische Wochenschrift*. No. 27, 1897. In genuine pneumonia a venous thrombosis is very rare. Only two such cases have been published. In typhoid and puerperal fevers they are quite frequent. I have seen one complicating the convalescence of typhoid. In other infectious diseases, cholera, small-pox, measles, scarlatina, articular rheumatism and influenza, they have been observed. In v. Leyden's and Guttman's collective statistics on influenza there are twenty-eight cases recorded. Laache, of Christiania, in 1893, published an interesting article on thrombosis complicating different diseases. His original article, published in the *Norsk Magazin for Laegevidenskaben*, also appeared in the *Deutsche Medicinische Wochenschrift*, 1893, p. 785.

FRANK H. PRITCHARD, M.D.

## THE GEOGRAPHICAL DISTRIBUTION, PROPHYLAXIS AND THERAPEUTICS OF TETANUS.

I. *Geographical Distribution*.—That tetanus should flourish more abundantly in tropical regions is to be expected when it is recalled that the germs grow most luxuriantly at body-heat, or heat in slight excess of normal human temperature. The nations that inhabit these regions are reported as "exceedingly susceptible" to the disease; but surely this can be disproved when we remember that these nations are less civilized than the inhabitants without the tropics, and that filthy carelessness of barbaric, semi-barbaric, or quadri-barbaric tribes may well account for the seeming difference in susceptibility. The dearth of reports from the North is very impressive, witnessing, probably, to the inability of the bacillus to flourish in cold climes.

Verneuil has laid stress upon the fact that in localities where horses are kept in considerable numbers the prevalence of tetanus is greater, relatively, and that the specific organism abounds in and upon stable-floors. He explains the occurrence of the disease on shipboard (as has been recorded in several instances) by pointing out that horses were fellow-passengers with the afflicted. Following along this line came the advancement of the equine theory of the origin of tetanus, but this was utterly thrown down by the experiments of Dantes, who made cultures in the New Hebrides Islands from the mud with which the natives poisoned their arrows, and found the bacilli of tetanus and of malignant œdema where no horses exist.

The disease is prevalent in Calcutta and all Bengal. "Tetanus is seldom absent from the Calcutta hospitals." Bombay yields a horrible tale, having 1955 cases in five years, not including puerperal cases. It is a common malady at Hyderabad. Remarkably numerous are the cases among the grain-dealers of Bania, who work in dust, and who frequently use manure as poultices for wounds and boils. In Arabia tetanus is prevalent, and also in Ceylon.

"Larrey had great experience of this disease during Napoleon's campaign in Egypt," says Erichsen. The meagre accessible details lead us to assume that Germany, Belgium, Switzerland, Spain and Portugal are the elected lands. Larrey had scores of cases after the battle of Waterloo, and this was merely a repetition of his experience after Dresden. Rose attributes some of the prevalence of tetanus in Switzerland to the frequent practices of dressing fresh wounds with mud or manure, or of obtaining hæmostasis by the application of spider-web.

England furnishes many cases. Concerning tetanus in Cuba, several authorities use the expression "truly endemic." Tetanus neonatorum is a dreadful plague here, the cases in Havana alone rising into the hundreds per year. Biart observed 417 cases in fourteen years of private practice here. An army medical officer saw 858 tetanics on this island (Dupont).

Boffier tells us that this malady is frightfully prevalent in Mexico, near the coast, and indicates Vera Cruz as a town where its fatalities are most numerous. Dr. Wilson (of the Brooklyn Health Department Laboratory) states that Yucatan has been recommended as an advantageous locality for investigating the clinical value of the antitoxin of tetanus, so many are the cases there always.

In order to indicate ever so indefinitely the geographic distribution of tetanus in the United States, only two classes of aids are at hand: scattered,



isolated statements about some town or county or State, and the observance of the localities in which reported cases have occurred. To the best of our knowledge, the sections where tetanic infection is most frequent are northern New York and along the Hudson Valley; Brooklyn and surrounding districts of Long Island; southern Pennsylvania; Virginia in its central, southern and eastern portions; Georgia, at least about Savannah; southern Louisiana, Indiana, Illinois, and southern California. Savannah's record has long been bad. In searching the medical and surgical history of the War of the Rebellion for geographic statistics but little satisfaction was found, but enough cases were detailed to indicate that cases of tetanus were plentiful after the battle of Gettysburg and after the engagement in the Wilderness. Lambert has isolated the germ from the soil in various parts of New Jersey.

Long Island is notorious for its great number of tetanus cases. Its eastern end has been particularly reviled as a hot-bed for the growth of this specific germ. Lambert has reported cultures of tetanus bacilli from various parts of Long Island, and about Brooklyn tetanus is common, considering the excellent care that we suppose the majority of badly-lacerated and punctured wounds and compound fractures receive.

II. *Prophylaxis*.—To begin with, a suggestion from the pen of Edmund Rose, found in his recent elaborate work on tetanus: "It is unwise to devour raw fruit and vegetables fresh from the garden, unless they have been thoroughly cleansed, nor should any fruit that has fallen to the ground be eaten unless so treated first. This is because of the possibility of an unhealed tooth-socket in the jaw, or of abrasions or fissures along the alimentary canal, which might act as the gates through which the tetanus bacilli may enter." Here may be the explanation of some of the cases of so-called "idiopathic tetanus." Again, germs thus swallowed might traverse the entire gastro-intestinal canal unharmed and innocent, and upon exit infect the anal region, or, at the time of labor, find their way into a lacerated perinæum or vagina, or into the uterine cavity, and give rise to an attack of puerperal tetanus.

Another point upon which this same author insists is the discarding of bandages or dressings which have fallen upon the floor. He thinks he has lost two cases from post-operative tetanus because the incised parts were enveloped in bandages which had been dropped upon the floor just previous to their use.

So many deaths from this disease have occurred after the reception of slight wounds that every surgeon should treat even the minutest scratches with scrupulous care, nor can this principle be too widely preached among the busy general practitioners of our day.

When wounds have occurred, what shall be their treatment, bearing in mind the possibility of tetanus, at least in a region where the soil is known to be badly infected? The surgical principles of the day seem to indicate thorough scrubbing with soap and water (scrubbing, not bathing), careful washing with alcohol or ether, irrigation and scrubbing with bichloride of mercury solution (1-1000), and a dressing of wet bichloride of mercury gauze, using proper drainage when the style of wound indicates.

The value of iodoform, silver nitrate in 1 per cent. solution, and iodine has been established by different observers.

Given a punctured wound, evidently dirty, or caused by the classic nail or splinter, or a pistol-shot wound, its treatment by free incisions so as to expose

every nook to the measures detailed above, seems in keeping with the spirit of modern surgery. Germane to this subject is the free incision of all spaces beneath the skin in compound fractures, by which measure alone can the thorough cleansing of these cases and the irrigation with antiseptic solutions be satisfactorily accomplished.

It is said that the tetanus bacillus is an anaërobe. It is truer to say that it cannot live in the presence of oxygen as such. Every molecule of hydrogen dioxide (or peroxide) contains an atom of oxygen which watches and yearns for an opportunity to spring away and oxidize some organic matter. It does so with pus-cells and blood-cells, and why may it not accomplish the destruction of the bacillus of tetanus? Thus we recommend its free use in washing and forcibly irrigating the suspected class of wounds, or every dirty wound, in a region where the soil is known to be badly infected.

Antitoxin holds a very important place in the treatment of tetanus, although whether it is established there positively is, as yet, a question. Amputation is not an obsolete method of treating tetanus. Cauterization has given excellent results in some cases. Excision of the wound and neurotomy have been practiced.—Goodrich, in *Annals of Surgery*.

**SURGICAL HINTS.**—Absorbent cotton does not make good padding for splints. Ordinary cotton batting is far more elastic, and will not gradually pack together by absorbing moisture from the skin.

Asepsis should be redoubled in operating in the neighborhood of joint-cavities. An infected knee is almost, if not quite, as serious a matter as an infected peritonæum.

An abnormal discharge from the nipple should always be regarded with suspicion, and a sanguinolent discharge should be sufficient cause for the most painstaking examination of the mamma, axilla and supraclavicular regions.

Not every joint that is red, swollen, painful, and accompanied by fever contains pus. Beware of opening an articulation affected by acute rheumatism, and remember that rheumatism may attack particular tissues, tendons, etc., as well as joints.

In plastic operations of the soft parts avoid tension and pressure on the flap. The flap should lie easily in its new position, sutures being necessary simply to insure accuracy of approximation, not to retain it in place by more than the suggestion of force.

When you are operating near a large vessel, such as the axillary vein or the jugular vein, it is always wise to expose the region freely, and when this has been done, to work away from it. It is demoralizing to work toward a dangerous point, feeling that the next stroke of the knife may be followed by an unwelcome inundation of blood.

Lacerations of the tongue, such as occasionally occur when one has fallen with the tongue between the teeth, should be carefully cleaned and sutured with silk. The application of cocaine in 4 per cent. solution makes the operation painless, and the treatment by suture prevents the persistence of flaps and unevenness of the surface which may become very annoying. In children the operation, and also the removal of the sutures, may require general anæsthesia.

One of the dangers in amputation of the breast is pneumonia, due to ex-

posure at the time of operation. The natural protection by the mammary gland and adipose tissue is taken away, and a moist evaporating surface very close to the lung invites subsequent congestion. Much danger may be avoided by covering all parts of the wound not at the time the actual seat of operation with hot, wet towels, and frequently changing them as they become cool. Hot water may also be occasionally poured over the protecting towels.—*International Journal of Surgery*.

H. L. NORTHROP, M.D.

**SYMPHYSIOTOMY.**—Zweifel has performed 31 operations in the University of Leipsic. All the mothers recovered without defect of any kind, and 29 mature children were delivered alive and dismissed from the hospital. The possibility of performing 31 such operations without a death and with complete recovery, shows that the pessimists have gone too far in opposition to this operation. The chief objection has been on account of difficulty in walking after the operation, due to defective formation of the cartilaginous tissue and lack of firmness after symphysiotomy. Experiment and practical experience have shown that the symphysis unites firmly by cartilaginous union, and some of these patients, within the first year after a pubic section, have been able to dance, which shows that the *restitutio ad integrum* could not have been better. All have their normal gait and are fully able to work.

It has already been shown, at the Eleventh International Congress in Rome, that symphysiotomy should not be performed with a conjugata vera of less than 6.5 cm. All the patients on whom he has operated had a conjugata vera between 6 cm. and 8.5 cm.

There is some danger from hæmorrhage in symphysiotomy, but no more than in Cæsarean section, and immediate compression of the innominate bones and an iodoform or sterilized gauze tampon before and behind the symphysis, with compression from the vagina, has been sufficient to arrest the hæmorrhage from the corpora cavernosa clitoridis and prevesical network of veins.

A large majority of the deaths following this operation are due to pyogenic and septic infection of the wound. After everything is sutured without draining, after arresting hæmorrhage, the wound heals well and rapidly without the entrance of infection; but there is no little risk from the collection of blood and serum and the inability to eliminate it. In some very favorable cases there was separation of the wound in the line of the suture, with slight rise of temperature and discharge of a quantity of wound secretion, followed by cessation of the fever and recovery of the patient. This experience taught him to always drain the pockets both behind and before the symphysis, and to use a compress on the abdomen, with the aid of a T bandage, to prevent the collection of the secretion. It is better to leave the pockets in the wound packed with iodoform gauze for eight or ten days, and to gradually remove it. The operation is only made for viable children for the purpose of rescuing them.

With the legs in a hanging position a transverse section is made through the skin from one to one and one-half finger's breadth below the upper border of the symphysis, and the bleeding vessels are ligated. The fascia over the symphysis and the linea alba over the pubic spine is laid open, and all the soft parts are dissected bluntly with the finger-nail down to the lower border of the



ligamentum arenatum. The fascia and linea alba are opened close over the symphysis and the prevesical connective tissue space opened. The symphysis is then divided; a female metallic catheter is introduced into the urethra and the index finger of the left hand pushes the bladder away from the posterior wall of the symphysis and from its lower border. Under the guidance of this finger a blunt bistoury is introduced and the symphysis divided *from behind and from above, forwards*. Immediately after the section the pubic bones separate from 2 to 4 cm., and the gaping wound is immediately packed with sterilized iodoform gauze, and, when possible, the patient is delivered immediately with support of the iliac bones. If immediate delivery is not possible, the pelvis is bound with a broad flannel or rubber bandage, and when the head has entered the pelvis a few hours later it is delivered in the usual manner.

The pubic bones are united as follows: (a) A female catheter is introduced into the urethra; (b) a long strip of iodoform gauze is introduced into the wound; (c) the symphysis is united by two catgut threads and two threads of unabsorbable material introduced either through the fascia and cartilage, or by drilling the bones; (d) gauze is introduced behind the symphysis with an aneurysm needle, so that in closing the sutures it does not become clamped between the pubic bones; (e) the bones are pressed together and the sutures are quickly tied.—*Monatsschrift für Geburtshülfe und Gynäkologie*, 1897.

COLPOTOMY, AND THE TOTAL EXTIRPATION OF THE UTERUS.—Doyen does not agree with the proposal of some operators to remove all ovarian cysts by colpotomy. (Vaginal incision.) It is possible to remove cysts which contain a large amount of fluid by the vagina without difficulty, if one is sure that there are no adhesions, and that the cyst is unilocular. The operation is contraindicated by extensive adhesions.

The anterior vaginal incision, in his opinion, is more dangerous than the posterior vaginal incision, which allows better drainage and better abdominal palpation, as to the condition of the posterior surface of the uterus and the adnexa. If the vagina is capacious, the diseased adnexa are more easily accessible than by laparotomy, especially in corpulent women.

In a unilateral operation, Doyen recommends the posterior colpotomy as the operation of choice, rather than ventral coeliotomy. The operation also has the advantage that if bilateral disease is found, it is an easy matter to proceed to the vaginal radical operation, which is far more effectual than removal of the adnexa alone. Abscesses which are developed in the broad ligament, or solid tumors in the same, if they do not exceed the size of a child's head, can be removed from the posterior vaginal incision.

Colpotomy posterior is especially serviceable for small adnexa tumors which lie in the cul-de-sac of Douglass, if unilateral removal is desirable. Doyen controls hæmorrhage by ligature or clamps. The latter have the advantage that they fix the stump near the upper portion of the vagina and prevent the discharge of infectious material into the abdominal cavity. In general the clamps are restricted to those cases in which the application of the suture is difficult. A well-placed clamp is always better than a badly applied ligature. Colpotomy posterior is not applicable for tumors extending above the iliac fossa into the abdominal cavity, or for tumors extending to the navel, or for

large ovarian cysts, as in these the existence of adhesions cannot be excluded with certainty.

In total vaginal extirpation, the patient is put in a position with the limbs extended so that the hip-joint forms an angle of about  $45^{\circ}$ , and abducted, and the vagina forms a horizontal canal. Doyen opens the Douglass cul-de-sac first, introduces the index finger, and examines the adnexa; if they are diseased he proceeds to complete the operation; but if the adnexa are in such condition as to cause sterility, he then incises the anterior vaginal vault, separates the bladder from the cervix as far up as possible, taking care to push the ureters well to one side. He then splits the anterior uterine wall in the middle, opens the plica vesico uterina, draws the fundus forward, protecting the bladder and omentum by a retractor. The appendages are everted and a large clamp applied from above downward and a smaller clamp outside as an extra protection. No preventive arrest of hæmorrhage is necessary, as hæmorrhage during the operation is usually very slight. The condition of the broad ligament determines the application of clamps or ligatures. If a ligature can be surely applied, as in prolapsus, and the broad ligament is quite elastic, so that the adnexa can be easily drawn down into the vagina, he applies ligature *en masse*; but this is not practicable in inflammatory adnexa tumors, and the clamp method shows better results.

Hæmorrhages dependent upon lacerations after the application of clamps can always be controlled by the application of another clamp. If the uterus is very large and fixed, the operation is made easier by a V- or Y-shaped division of the anterior uterine wall. Any myoma situated in the true pelvis can almost always be extracted piecemeal by the vagina. In prolapsus, to avoid injuring the bladder, Doyen usually opens the posterior wall of the uterus and separates the bladder as the last act of the operation, and retroverts the uterus from the vagina. The ligaments are ligated after the uterus has rotated at an angle of  $180^{\circ}$  to produce a torsion of the ligaments.—*Ibid.*

THE UNDULATORY CURRENT IN DISEASES OF WOMEN.—G. Apostoli has tried the undulatory current in 156 cases and 1170 sittings. The treatment of malignant tumors and suppurative disease was excluded. The treatment can be given daily or every second day without injury to the patient, for a duration of five minutes at a time. The electrode covered with cotton was introduced only into the vagina (786 times); at other times into the uterine cavity or the cervical canal (384 times); and in the last two instances a platinum electrode was employed. The current can be increased to 15 or 25 milliamperes without difficulty, and but very rarely to 50 milliamperes. The undulatory current promotes the absorption of periuterine exudates and the separation of adhesions, but has no effect on myomas. It is an effectual analgesic for intermenstrual pains. It has been especially effectual for dysmenorrhœa, which disappears entirely after either vaginal or intracervical application of the current, which must be frequently repeated, especially just before the menstrual period. The current has very little effect on uterine hæmorrhage, and may even cause it in intrauterine application. The vaginal application is ineffectual for leucorrhœa, but it is often a valuable remedy if applied within the cervix. Amenorrhœa treated by the application of the negative pole is not so favorably affected as similar treatment with the constant current. The intracervical use of the current has been an excellent remedy for constipation.—*Ibid.*

GEO. R. SOUTHWICK, M.D.

## MONTHLY RETROSPECT

### OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

---

**CHOPCHEENEE**  $\phi$  IN SYPHILIS.—This is a plant indigenous to India and other eastern countries. Some Indian medical writers are of the opinion that this medicine was introduced into India by Chinese traders. However it be, this much is certain, that this medicine has been in use in India for a very long time, as we find evidenced by medical works written some three hundred years ago. The root is the only part used as medicine; it is said to be useful in rheumatism, epilepsy, insanity, and particularly syphilis. It is a most renowned medicine for syphilis in India. Its action is more decided in the secondary stage, especially when the skin and mucous membrane are the seat of suffering. It is a non-poisonous plant, and so its action is mild and not so violent as that of mercury; still it is in no way inferior to the latter in its efficacy in syphilis when the disease has gone to the secondary stage.

Dr. Gangadin, of India, says: "I have in my practice seen its wonderful action in hundreds of cases of secondary syphilis. (I don't think it has any action in its primary or tertiary stage.) I have prescribed it in the following conditions of secondary cases with great benefit. It has invariably proved itself not only a relieving but a radically curing remedy.

"1. Eruptions of every kind—exanthematous, papular, vesicular, tubercular, pustular, squamous and ulcerative.

"2. Mucous troubles of the throat—irritation, inflammation or ulceration.

"3. Syphilitic condylomata or other excrescences.

"4. Nocturnal pains in the muscles and bones, which are generally present during the secondary period.

"5. Syphilitic rheumatism.

"*Administration.*—The action of the medicine is generally known within one to three weeks; it should be continued for a sufficiently long time, according to the severity of the symptoms and chronicity of the case. I have always used it in tincture form. Dose: 10 to 30 drops in an ounce of water three times a day."

**THE TREATMENT OF MEMBRANOUS CROUP.**—Newberry, of Iowa City, in a paper read before the Missouri Valley Homœopathic Medical Association, reviews the question as to the identity of membranous croup with diphtheria, and is inclined to decide in the negative. In treatment he advocates active and prompt measures, both general and local. The inhalation of moist medicated air is beneficial. A steam atomizer can be brought into requisition, or, when this is not at hand, a dish of boiling water, so covered that the patient gets the benefit of the fumes, is of service. The medication used in the water may be bromine, iodine, compound tincture of benzoin, carbolic acid, acetic acid, or various other substances with a penetrating odor, the object being to reach and cause the exfoliation of the membranous deposit. The use of the inhalation of slacked lime occasionally produces good results. The writer, however, has had better results from the use of a spray in the throat with a good



hand atomizer than with the inhalation of medicated air. The two remedies thus used are peroxide of hydrogen, diluted one-half, and permanganate of potash, one grain to the ounce. He has seen the exfoliation of large casts immediately after the free use of one of these remedies.

As to internal medication, in his opinion kali bich. stands at the head of the list. He has used it in a low potency in several cases with excellent results. One case, in a boy of 8 years, with almost complete occlusion of the larynx, yielded to the administration of kali bich. internally and permanganate of potash locally. No other remedies were administered, and the child made a speedy recovery. Other remedies are aconite, arsenicum, iodine, bromine, hepar sulph., tartar emetic, sanguinaria, calcium iodide and mercurius. Intubation and tracheotomy have prolonged many lives after remedial measures have failed. Intubation, if properly performed, in a large percentage of cases gives instant relief, tides the patient over the critical stage, and places the little sufferer on the way to recovery.—*Medical Era*, December, 1897.

THE PATHOLOGICAL CHANGES INDUCED BY APIS MELLIFICA.—Dr. Gibbs Blake, realizing that while the provings of apis mellifica are full they are wanting in respect to pathological changes, calls attention to a paper by Dr. Langer, of Prague (*Archiv für Experimentelle Pathologie und Pharmacologic*, Band 38, s. 381). Dr. Langer thinks that the post-mortem appearances, the local necrotic and irritating effects of a small quantity of the poison, its power of destroying the red corpuscles and the production of hæmorrhage, place the bee-poison in the same category as that of vipers and rattlesnakes.

The local application of the bee-poison produces a necrosis of the tissues in the centre of the spot to which it is applied. Around this centre there is infiltration of round cells, œdema and hyperæmia. Phagocytes help to eliminate the poison. The local application also causes the animal to eat and drink a larger amount than in health, and often produces albuminuria. The results of gradual intravenous injections of 6 cc. of a 1.5 per cent. solution of the pure bee-poison were thus given. In fifteen minutes after the first ccm. was injected the diminution of blood-pressure was very marked, with slowing of the pulse. Gradually the blood-pressure increased, and almost recovered its original state. The further injection of  $\frac{1}{2}$  to 1 ccm. did not again produce diminished blood-pressure, but continued movements seemed to increase the blood-pressure. Clonic spasms became gradually universal, with trismus, nystagmus, and emprosthotonos. During brief pauses of spasm the animal lay on its side paralyzed. Respiration gradually ceased.

Post-Mortem.—The pupils were widely dilated, the brain full of blood, but no hæmorrhage into its substance. Veins of meninges full of blood. Pericardium completely distended with blood-stained serum. The right side of the heart much dilated, the left contracted; fluid dark blood with some fresh clots in the cavities of the right heart; the endocardium, as well as the intima of the large vessels, markedly stained rose color. Microscopical examination of the blood showed very few red corpuscles; the blood very lake-colored, with much dissolved blood coloring-matter, and with the spectroscope showed metaglobin. The lungs were full of air, and small hæmorrhagic infarctions were seen on the outer surface. The liver was much congested; no hæmorrhages were visible; the gall-bladder purplish; the mucus lining much congested and blood-stained. No obvious change in the spleen. The kidneys were much congested and the tissue uniformly discolored with blood; the pel-

vis also much congested. No urine was found in the firmly-contracted bladder; many ecchymoses the size of a lentil were found on its mucous membrane. The intestinal canal was stained throughout with blood; the duodenum, jejunum and ileum contained bloody mucus. On the peritoneal coat of the stomach there were many hæmorrhagic spots. The pancreas was infiltrated with blood. The glands of the mesentery also showed lenticular hæmorrhages.

Blake concludes that in this proving the use of apis for dropsical effusions is confirmed, and especially for effusion into the pericardium. The proving also suggests the use of apis in the exanthemata, when accompanied by hæmorrhages, especially as they are met with in measles of severe type.—*Monthly Hom. Review*, Dec. 1, 1897.

**MERCURIUS CORR. IN LOCOMOTOR ATAXIA.**—Delamater, of Chicago, records the case of a man 39 years of age who presented all the classical tabetic symptoms, including gait, ataxia, lost knee-jerks and anæsthesia, together with a history of probable syphilitic infection, at the age of 27. The diagnosis of locomotor ataxia was made unhesitatingly, and merc. corr. 3x trit. was given three times a day. For a month he reported steady improvement, but two weeks later he did not seem so well, and complained that the legs were colder, pains more severe, and formication in legs and feet. Ergot 3x trit. was given for two weeks. At the end of that period he was improved, and merc. corr. 3x was resumed. At the end of six months every trace of the trouble had disappeared, and six months later he was still in apparently perfect health.

Was it locomotor ataxia? The symptoms and history seemed conclusive, but Prof. Delamater does not believe that there could have been any sclerosed tissue in the patient's anatomy. It seems impossible that any remedy could cause such nutritive changes that in so short a time sclerosed tissue could be replaced by healthy. He is inclined to believe the condition simply one of congestion of the cord, and that the use of ergot for two weeks was sufficient to constrict the bloodvessels, while merc. corr. assisted in the process by its action on the blood.—*Medical Counselor*, October, 1897.

**BAPTISIA IN TYPHOID.**—Martin, of Lowell, regards baptisia as a good fifth to bryonia, rhus, arsenicum and hyoscyamus in the treatment of typhoid fever. The baptisia patient feels chilly all day and hot at night; chilliness and soreness of the whole body, with intolerance of pressure on lying; the pulse is soft, full and quick; heavy, dull, bruised sensation in the head; stupefying headache; confusion of ideas; nightly delirium, with stupor; heavy sleep, with frightful dreams; patient can scarcely be roused long enough to answer a question; he changes position frequently because the bed becomes too hard. The face is dark red, with a besotted expression; dark sordes on teeth and gums; tongue dry and red, or coated brownish, with red edges; breath very offensive.

Fetidty is the marked characteristic of the advanced baptisia typhoid. The breath, sweat, urine, stool, all are offensive, and a certain tendency to ulceration is often present. Marked debility with nervous depression, and a tired, bruised, sick feeling all over the body. In the mental sphere, where peculiar symptoms so often help us to our similimum, baptisia shows "the patient cannot go to sleep, because she cannot get herself together; her head feels as if scattered about, and she tosses about the bed to get the pieces together." A feeling as if the lower limbs were severed from the body, or as of a second self alongside in bed, are symptoms that have been verified repeatedly.—*Medical Era*, Dec., 1897.

F. MORTIMER LAWRENCE, M.D.

# THE HAHNEMANNIAN MONTHLY.

---

FEBRUARY, 1898.

---

A CLINICAL LECTURE ON ACROMEGALY, THE MUSCULAR ATROPHIES,  
ATAXIC PARAPLEGIA, AND CEREBELLAR TUMOR.\*

BY CLARENCE BARTLETT, M.D., PHILADELPHIA.

(Delivered at the Hahnemann College Hospital, November 17, 1897.)

GENTLEMEN: I have to bring before you first this morning two very remarkable, as well as unusual, cases of an exceedingly rare disease. So far as the histories of these patients are concerned, we find in them nothing of much value from a medical standpoint. In other words, their histories are negative. Now let us see what we can observe by examining them.

I will first bring to your attention this gentleman, whom I will call "X. Y. Z.," and ask your consideration of the following points: In the first place you will notice his hands; they are disproportionately broad. You can readily see that the fingers are of the same width at their tips as they are at their bases. You will observe that the finger-nails are broad and flat; you will also notice that their large size is dependent upon the soft parts as much as it is upon the bones. On making measurements, I find that the forefinger of the right hand has a circumference of three and three-quarter inches; that of the left

---

\* Reported stenographically by F. E. Wessels, medical stenographer.



is the same. I find that the hands at the knuckles measure ten inches in circumference, and that, including the metacarpal bones of the thumbs, they measure twelve and one-half inches. So much, then, for the hands. Next scan his face. You will notice, first, a very marked prominence of the lower jaw; in fact, the lower jaw protrudes further forwards than does the upper. In other words, we have the condition which is technically known as prognathism, and this prognathism is one of the most prominent symptoms of the disease from which both of these patients are suffering. Proceeding still further with our examination of the face, we notice a remarkable prominence of the malar bones—so great, indeed, that a deep crease has been formed between them and the nose. The nose itself is much enlarged, though well shaped. Measurements taken in my office tell me that the length of nose from root to tip is two and a half inches, that the distance from zygoma to zygoma is five and a quarter inches, and that the depth of the chin is two and a quarter inches. The supraorbital portion of the frontal bones is very prominent, while the rest of the cranium presents no abnormality to casual inspection. The presence of this supraorbital enlargement gives one the impression that there is a retreating forehead, which is really not the case. Examining still further, we find the external occipital protuberance greatly enlarged; indeed, it is raised fully an inch above the surrounding cranium. I can take a firm hold of it, and move the patient's head from side to side, against considerable resistance on his part. So much, then, for the external features of the head and hands. The tongue, you see, is enlarged. The ears I do not consider abnormal.

While this patient is preparing for us (undressing), I will have Mr. A. B. C. come forward. I have used arbitrary initials in designating both patients, because they have presented themselves before you as a favor to me and a matter of personal interest to you. Hence I wish to keep their identity secret. Mr. C. is now forty-two years of age. He first noticed, a number of years ago, that his lower jaw was becoming prominent. This deformity has increased up to the present time; indeed, this prognathism, as I called it a few minutes ago, is much more prominent in this case than it is in the case of Mr. Z. If I may venture a guess as to its extent, I should say that the

FIG. 1.



Case of Mr. C.

FIG. 2.



Case of Mr. Z.

FIG. 3.



Case of Nora —.



lower jaw protrudes beyond the upper nearly one inch. Observe also the shape of the inferior axilla. Notice that all this hypertrophy in the lower jaw is due to enlargement of the body of the bone, and not to alterations in its rami. As in the preceding case, the supraorbital ridges are prominent, giving the appearance of a receding forehead. The malar bones are prominent, but much less so than in Mr. Z.'s case. You will see that the shape of the nose is pretty much the same in both patients. I find some enlargement of the external occipital protuberance, but it is by no means as great as in the other case. It is not sufficiently large for me to take a firm hold of it.

Both of these gentlemen can recall that they have been getting larger in the head and extremities for many years. They have noticed that they have required successively larger hats, gloves, and shoes. I have seen photographs of both patients, taken years ago. Mr. Z. (who is the larger of the two), at the age of twenty-one, was of slight build, and had long, tapering fingers, and his hands looked like those of any other person.

Now that Mr. Z. is ready for us, I call your attention to his body. Notice that he is large all over. I do not, however, notice what is very common in this disease, a prominence at the ensiform cartilage; nor do I observe what also is common, a stooping of the shoulders. The shape of the thorax, aside from its size, is also normal. On pressing upon the soft parts and delineating his ribs, I demonstrate that these bones are of enormous width—certainly an inch or an inch and a half in width. In this connection I might say that there is nothing wrong noticeable about the long bones of the extremities. The neck is rather thick, but hardly more so than that of any man of his height and age. He is now forty years of age. The enlargement in Mr. Z.'s case is known to have begun at about the age of twenty-one or two years. Photographs taken at the age of twenty-eight demonstrate that the disease had progressed quite considerably by that time. The photographs taken four or five years ago compared with those taken by myself a few days since seem to indicate that the face is not as relatively long as it was. Furthermore, I might say, regarding this case, that the measurements taken by me last Friday evening were all one-fourth of an inch less than those taken four years ago. The former measurements were made by Dr. Der-

cum, of this city, who reported the case in the *American Journal of the Medical Sciences* for March, 1893. The case was regarded as such an excellent example of the disease that the patient's picture has since appeared in two text-books.

Mr. C. has prepared himself for inspection of his body. We find nothing abnormal in the thorax. I note, however, that he has an enlargement of the thyroid gland—a condition that I have not hitherto observed, but which has been reported by other clinicians.

The disease of which you have seen two such well-marked examples is acromegaly, a malady first described by Pierre Marie in 1886. There can be no question that it existed years before, and that cases of it were described as examples of gigantism, myxœdema, osteitis deformans, elephantiasis, and possibly other diseases.

Regarding the recognition of this disease, it is very remarkable that but few of its victims consult a physician because of the acromegaly. They consult him for some other complaint, usually for headache. Some remain entirely unaware of the fact that they are ill. Mr. Z. was one of the latter. Visiting his brother, who was a patient of Dr. Dercum, his trouble was first recognized. Mr. C. came to our hospital with pains which suggested the possibility of renal calculus. Our surgeons were not satisfied with such a diagnosis, and referred him to me. One of my patients (the first case of acromegaly I ever saw) came to our college dispensary, in 1889, for the relief of headache. Last year another case presented himself to us because of vertigo. I am unable to present either of these cases. Daniel G. (my first case), while intoxicated, three months ago, fell from the Reading Station at Spring Garden Street, and was killed. The fourth case was not to be traced. Acromegalic patients are not apt to consult their physicians because of their complaints, because they regard their enlarged extremities as a healthy growth. Mr. C.'s family physician, who has attended him, at intervals, for several years, has never taken cognizance of his peculiarities.

The case of Daniel G. first came under my observation in 1889, when he applied at the dispensary to be relieved of most horrible headaches. At that time he was forty-three years of age. Twelve years before he began to notice what he called a para-

lytic condition of his lower extremities. In walking he felt as though some one stopped him suddenly, and then his legs would give out. One year later he began with headaches, the pains being sharp and stitching, and were compared by him to "a nest of wriggling eels in the vertex." Sometimes the pains extended into the occiput. On three occasions he stated that he was demented by the pains. At the time of the examination he walked with a staggering gait. Both knee-jerks were abolished. His sexual powers were gone. He gave no history of syphilis or gonorrhœa. His skin had a pale and waxy hue. He had an occasional diplopia. The notes state that he had limited visual fields, especially so upon the right side, in the right eye. He had a vertical nystagmus. He was decidedly emotional in temperament. His hands and feet and head presented the characteristic appearances of acromegaly, as you have observed them in these two cases. There was marked stooping of the shoulders.

After being under observation with us for nearly a year this patient disappeared. I next read a report of the case published by Dr. F. A. Packard, in the *American Journal of the Medical Sciences*. From this I learned that the patient went to the University Hospital in 1885, and that at that time he suffered from hemianopsia of the bitemporal variety, but the fact that he suffered from acromegaly was not then recognized by his physicians. Subsequent perimeter examinations showed that the hemianopsia disappeared to a considerable extent, although the visual fields remained impaired.

After being a victim of acromegaly for at least twenty-two years, this patient died as the result of injuries sustained, while intoxicated, at the Spring Garden Street Station.

Now let me make a few remarks on the diagnosis of acromegaly in general. The first liability to diagnostic error lies in the confusion of acromegaly with myxœdema. The latter is a disease arising from deficiency of the thyroid secretion. The enlargement is universal and symmetrical throughout the body. The bones do not participate in the enlargement. In other words, the increase in size is limited strictly to the soft parts. The face, instead of being elongated, as in acromegaly, is round or moon-shaped; the eyelids are baggy; the soft parts are universally swollen, and yet there is no pitting on pressure, as in anasarca.



Gigantism is still another condition which may be confounded with acromegaly. I had hoped to be able to exhibit before you a very good illustration of this condition in the person of a young German, aged twenty-six years, who is six feet seven inches in height. Now, this case of gigantism differs from those of the two gentlemen already exhibited before you, in that the enlargement is universal. All parts of the body are large, and are in proportion to each other. In acromegaly the hands, feet and face are disproportionately large to the rest of the body. One prominent authority—I forget who it is—states that a man's foot should be about one-sixth of his height. In cases of acromegaly the feet are more than a sixth of the height. In gigantism the reverse condition is observed; *i.e.*, the foot is large in proportion to the height, or it is relatively small. Then, too, in gigantism the shafts of the bones are long; in other words, their great size is not alone noticeable at their ends.

From what I have seen of elephantiasis, it is hard to say how this condition could be mistaken for acromegaly. In the first place, the enlargement in this disease is limited to one, or at the most two extremities; and, in the second place, the hypertrophy is of the soft parts, the skin and subcutaneous tissues being affected. The hypertrophied skin hangs in folds.

Nor does the mistaking of acromegaly for osteitis deformans seem any more likely, and yet it is known that this diagnostic error has been made. Osteitis deformans never occurs before forty years of age; the deformity is found in the long bones, and not in the hands and feet, this deformity consisting of curvatures. These are noted in one limb alone, or they occur in one limb far in advance of others; and any deformity of the head is noted in the cranium, and not in the face. In all of these particulars you will see at once that osteitis deformans is at variance with what we have observed in these cases of acromegaly.

Even arthritis deformans, which has lesions limited to the ends of the long bones, presents anything but similarities to acromegaly. The changes in the joints are accompanied by local pains, and by great deformity other than concentric increase in size of the extremities of the bones. Sooner or later the joints become ankylosed, and the muscles moving the affected joint undergo marked atrophy. The fingers, instead

of being broad and flat, are thin and long, and their joints are marked by enlargements and deformities. The finger-joints are, moreover, ankylosed or stiff, and in advanced cases fixed in disabling position.

Osteo-arthropathie hypertrophiante pneumique is a condition also described by Marie, and is characterized by an enlargement of the extremities which is usually associated with disease of the lungs. I say usually, because a few cases have been reported in which the lungs were healthy. The enlargement is usually in the hands (but it may involve the ends of the long bones) and in the joints. The elbows, shoulders and wrists are often involved. The finger-nails, instead of being broad and flat, curve over at the sides and ends of the fingers, giving the latter a claw-like appearance.

Attempts have been made to class local hypertrophies with acromegaly, giving these conditions the title of "partial acromegaly." Systematic examination will always show important reasons why such an opinion should not be given.

While on this subject, some remarks concerning a patient I saw with Dr. Lukens at Wilmington eighteen months ago may be in order. Unfortunately I saw the case with him while visiting another patient, and I stopped in as a matter of interest to fill up the time while waiting for a train. Consequently the case was not as thoroughly examined as I would like. The history is this: The patient, Benjamin U. by name, had been an invalid all his life; while never sick, he was constantly languid and tired. He grew rapidly, and at the age of sixteen years was 6 feet 2 inches in height and weighed 165 pounds. He had never had any of the children's diseases excepting whooping-cough. At the age of sixteen years he had crops of boils; at the age of eighteen years he had a fall, injuring his back. Since then he had always complained of his back. He was never able to sit or stand without supporting his back, and yet he could walk well. At the age of twenty-one he had improved so that he felt better than ever before. At twenty-two he was taken with his last illness, the symptoms of which commenced with severe pain in his back, extending down the legs; pains were intermittent. The bones at the wrists and ankles began to enlarge, and at the time I saw him were enormous. Dr. Lukens said they were twice their normal size. I remem-

ber that I made measurements, and that at the autopsy they were larger than at my visit. For a long time he had an ataxic gait, which increased in severity until finally he lost all power over the legs. After this the flying pains were all he complained of until the last week of his life, when there occurred a complete suppression of urine, and he had a uræmic convulsion and died. At the time of my examination his knee-jerks were absent, and both legs were absolutely powerless. They were also anæsthetic. A most remarkable condition existed in the back. From the lowest ribs down the usually soft parts of the back were just as hard as a board. Percussion here brought forth a sound as if one were pounding on a hard surface like a board. It appeared as if the muscles of the back were ossified.

We had an autopsy, and that autopsy developed a most remarkable condition of affairs. Unfortunately for the advantage of medicine, Dr. Hall could not go to perform it, and I had to do it myself, and unfortunately, also, the family was very strict in enforcing a request that no tissues should be removed for examination. So we had to respect their wishes as far as we could consistently do so. Examination was limited, also by request, to the spinal cord and the joints. The condition of the vertebral column was a remarkable one. Apparently the arches of the vertebræ were decalcified, for I could cut through them with ease, using only an ordinary scalpel. I really believe that the opening of that spinal canal made a record for a rapid post-mortem examination of that part. Still more remarkable was the fact that the bones of the vertebræ, in undergoing decalcification, had acted just as does a sponge in absorbing water. The arches became greatly swollen, and in so doing had obliterated the spinal canal. The compression thus exerted had destroyed the spinal cord, so that in the lower portion of the spine the spinal canal contained only a fibrous cord. Thus was the paraplegia accounted for. I examined further, and incised the ankle enlargement. You know how you plug a watermelon. Well, with a scalpel I plugged the extremity of a tibia in that way, and removed a wedge-shaped piece of bone, which also was found to have undergone softening, though it was not completely decalcified. Incising the muscles of the back over the seat of calcareous infiltration, they were found densely studded with gritty particles. This



constitutes the case. What it was I do not know; at least, no possible explanation that has been offered satisfies me. Osteomalacia, osteitis deformans, myositis ossificans and rachitis have been suggested, but the clinical phenomena of these diseases do not correspond with my case. Osteomalacia is a disease occurring for the most part in women. Occurring in males, it is so rare as to constitute a clinical curiosity. It is accompanied by bending or fractures of the long bones—the latter, when the softening involves the interior of the bones, leaving an outer brittle shell, bending when the softening invades the entire bony thickness. In my case, apparently, the brunt of the disease was borne by the joints. It is unfortunate that clinical and pathological investigation of this case was so incomplete. For the case to have been of scientific value the clinical examination should have been more thorough, and the autopsy should have involved practically an entire dissection of the body, and many microscopic examinations of every tissue and part.

To return, now, to the subject of acromegaly. It remains for us to speak of prognosis and treatment. At present we must regard this disease as an incurable one. It is usually taught that cases of this disease succumb in about twenty or thirty years. I think that this is taking altogether too grave a view. Daniel G. had the disease at the age of twenty-one, and died at fifty, as the result of an accident, apparently in as good physical condition as he was in 1889. Dennis McL. is sixty-five years of age, gains his livelihood as a clerk, and complains only of vertigo. The patients before you are in good health, so far as physical ability or comfort is concerned, though neither one is more than ordinarily strong. They have been victims of acromegaly for twenty years. While sexually weak, Z. claims that he enjoys sexual intercourse in moderation, and C. is still continent. Reference to the sexual life of these cases leads me to say that loss of the sexual desire in men is a prominent early symptom. Women are affected with amenorrhœa. Z. has a healthy son aged seventeen years. C. has six children, the oldest being twenty years of age, and his wife is now pregnant for the seventh time. He is anxious to know if the disease is hereditary. I tell him that, so far as we know, heredity exerts but little influence.

Z. has never undergone any treatment. He is disinclined to do so, as he feels well. C. took Fowler's solution several years ago, and it gave him great relief so far as his back pains were concerned. He has, however, increased in size since I first saw him. Of late years autopsies on patients dying with acromegaly have demonstrated an enlargement or tumor of the pituitary body. This, as you know, is one of the ductless glands, and it is believed that it manufactures a secretion which should be taken up by the system, and the absence of which produces the enlargement of the extremities. Similarly, the deprivation of the system of the secretion of the thyroid gland causes the condition which we call myxœdema.

Doubt on the pituitary origin of acromegaly has arisen because reliable observers have reported cases of disease of this structure in which there were no enlargements of the extremities. Thus far such observations must be regarded as valueless, because in none of them has it been demonstrated that the entire gland was destroyed. You know that if, in the case of removal of the thyroid gland, a portion of its structure is permitted to remain, the characteristic symptoms of myxœdema (or cachexia strumipriva) do not assert themselves.

My proposition for treating these cases is this: First, make an attempt at feeding the patient on thyroid extract, giving from five to ten grains of the dried extract three times daily, and persist with this treatment for three or four months. At the end of that time we will make further measurements, and note if the patients have improved under the treatment. If that fails, I shall then advise the trial of pituitary extract. This has been tried in some few cases, and it is claimed with good results, forty grains of the gland being given daily. I must say, so far as my knowledge of the literature is concerned, I cannot speak of encouraging results.

The next case will be brought before you in rather a remarkable garb, which needs some explanation. Let me say it is done in deference to the wishes of the patient, who appeared once before at a general clinic, and owing to the ungentlemanly conduct of the students, she refused peremptorily to come before us to-day. But I promised her gentlemanly behavior on the part of the class, for that is always the custom here, and I also promised her that she should wear a mask to conceal her

identity, and that she should be draped anteriorly, as I wished only to have you inspect her back.

The patient is Nora —, eighteen years of age. In early childhood it is known that she had a peculiar walk, but it does not seem to have excited any particular comment. It became more marked as time went on, until, several years ago, walking became difficult, especially on going up stairs. The left leg seemed to give more trouble than the right. In walking there is a swinging of the body from side to side. On rising from a sitting position, she assists herself by sustaining the weight of the body with the left arm on the left knee. Gradually there has appeared a weakness of the shoulders and back, and this has increased to such an extent that the shoulders and scapulæ muscles are almost functionless. She considers her digestion to be good, although the taking of strong food for any length of time will finally excite vomiting. Her appetite is not good. She suffers but little from headaches, probably three or four times in the course of a year. She began menstruation at the age of sixteen years. The family history gives no information as to the etiology of her illness.

Testing the knee-jerks, I find them absent. Asking her to stand with heels and toes together, we find her perfectly steady, although she is blindfolded; static ataxia is therefore absent. The muscles of the leg, with the exception of the quadriceps extensors, are of normal appearance, and have the natural firmness to manipulation. The quadriceps muscles, especially the left, have undergone some atrophy. Inspecting her back and shoulders, we find the scapulæ receding from the vertebral column, so that they occupy a position on a line with what should be the shoulders. The inner edges of both stand out from the thorax like a miniature pair of wings. The scapular muscles are atrophied, as are also both deltoids. The ribs are plainly visible. The latissimus dorsi muscles are atrophied. Anteriorly we find the pectoralis major muscles wasted. The neck is thin, this condition also arising from muscular atrophy.

We have, then, on which to base a diagnosis, a history of a peculiar walk from early childhood, and subsequent atrophy of the muscles about the shoulders, unattended by pain of any kind, no static ataxia, no disturbance of sensation, and absent knee-jerks. Although the first signs of the complaint were



observed in the lower extremities, the muscular atrophy is most prominent in the upper. Evidently this case belongs to one of the muscular atrophies. Inasmuch as it made its first appearance in early childhood, we are furthermore led to say that it is one of the muscular dystrophies. The history of disturbed gait, with swinging of the body and absent knee-jerks, and preservation of the normal size of the calf-muscles, and subsequent atrophy of the muscles of the upper extremities, is suggestive of the disease we know as pseudo-hypertrophic paralysis. Ordinarily, in this affection, we find the calf-muscles greatly enlarged; so much so, indeed, as to give the observer the impression that the parts possess unusual strength. In this case we find the calf-muscles normal in tone, consistency and size, thus throwing doubt on the diagnosis of pseudo-hypertrophic paralysis. On the other hand, you must remember that in typical cases of this disease atrophy of the upper extremities, such as we observe in the patient before us, is a common feature of the advanced stages, and that the pseudo-hypertrophy may be overlooked or is apparently absent. Perhaps it would be well to discard the term pseudo-hypertrophic paralysis entirely as a distinct clinical entity, and speak only of a type of progressive muscular dystrophy of which muscular enlargement is a symptom.

Next I bring before you a case which has been diagnosed as muscular dystrophy. The patient first came under treatment in this institution on November 21, 1895. "Two years before that he fell from a frame in a mill, and struck on his right hand, falling a distance of about eight feet. He did not think, at the time, that the arm was seriously hurt. Six months afterwards he began to complain of pain, which has since ceased entirely, excepting when he makes attempts at heavy lifting. There is observed considerable atrophy of all the muscles of the right arm up to the deltoid. He holds the right forearm pronated, and it seems to be fastened in that position by adhesions. There is no tenderness. The biceps and triceps jerks on both sides are equal. There is atrophy of the thenar and hypothenar eminences. Faradic action is preserved. Galvanic reactions are normal qualitatively."

In the two years that have elapsed since the above notes were taken the patient has made a distinct improvement, thus demonstrating that the case is not progressive. The electrical re-

actions show that the case is not one of neuritis or poliomyelitis. All this, to my mind, demonstrates that this is a local muscular atrophy dependent upon traumatism, and not one of the constitutional muscular atrophies, such as we saw in Nora's case. The treatment has been exclusively phosphate of strychnia, 3x trituration, a two-grain powder being administered three times daily.

Next there is brought before us a case which I have not seen before, and which I am informed is an example of muscular atrophy. I can only remark on the case in a most casual manner, for our hour is about closed. I would have preferred to present this and the succeeding cases at our next clinic, but they have come to us from a distance, and I must show them to you while I have the opportunity. Note that in this man there is extensive atrophy of the muscles of both upper extremities. Notice also the fibrillations of the wasting muscles, which are so marked, indeed, that I must characterize them as beautiful. The separate muscle-fibres fairly dance beneath the skin. We have no time to go into the history of this case. Let it be sufficient for me to say that it is an example of spinal muscular atrophy. The question is suggested, How do we differentiate spinal muscular atrophies from the primary dystrophies. I answer very readily. The spinal disease is not an hereditary or family affection; the changes are first observed in the upper extremities, and fibrillary twitchings are prominent features. The primary dystrophies are hereditary or begin early in life; fibrillary contractions are absent, and electrical reactions are normal until the muscular destruction has proceeded to complete atrophy.

Here is a case of spastic ataxia in a man of middle age. Our notes say that "this man was in good health until five years ago, at which time he had typhoid fever, followed by relapse. Ever since, he has had difficulty in walking, which has been getting progressively worse. He is worse in winter, and he occasionally, when walking, has sharp, shooting pains down the leg. He suffers from frontal headache for about an hour each day, generally relieved by rest; occasional diplopia; inco-ordination of gait; static ataxia; knee-jerks greatly exaggerated; spastic condition of leg-muscles; ankle clonus on both sides, more marked on right; spastic rigidity on sudden move-

ment of either leg; feet always cold, and occasionally numb; limbs go to sleep readily; bowels constipated; occasional urinary incontinence; pupils react normally. Is unmarried. Acknowledges excessive venery; denies syphilis." At present the ankle clonus is but slight. Dr. Bayley informs me that it has been growing less prominent for some time. You will notice that when walking he "interferes," to borrow a term from horse parlance. I mean to indicate that in taking steps the toe of one foot catches against the other. He has been taking lathyrus in the tincture, because this drug in poisoning cases produces a clinical picture similar to that presented by his disease. It is not doing him any good, for his illness has proven slowly progressive.

Lastly, I bring before you a little colored girl. She is bright and of good intelligence. She gives a history of repeated attacks of hemiplegia, if we are to credit the statements of her family. Notice that the left eye stands wide open during routine winking; nevertheless, she is able to close the eye on voluntary effort. You will observe, also, that the muscles of the corresponding side of the face are paretic. Getting her out of bed to walk, and for this she requires assistance, you will notice how incoordinate are her leg-movements, and how she slings these members about. I have brought her before you at this late hour simply because her parents insist on taking her home this afternoon, and I am unwilling to let this opportunity for exhibiting a well-marked example of cerebellar ataxia pass by.

---

F. W. HEADLAND, M.D., ON HOMŒOPATHY.

BY CHAS. S. MACK, M.D., LA PORTE, INDIANA.

I FEEL sure that an accurate definition of the immediate end sought in any given practice of homœopathy will prove to be the forerunner of greater and even more substantial growth than homœopathy has yet experienced. An accurate definition of that cure will not only show the difference between that and other cures, but will show that that particular cure transcends the possibilities of rational practice. This whole matter is



clearly set forth in my little book, *Principles of Medicine*, recently published by the W. T. Keener Company, 96 Washington Street, Chicago. I believe that that little book throws a flood of light into the darkness in which the old school now is upon the subject of homœopathy, and that it will prove useful to any of our own recent graduates, and to others in our own school (if such there be) who do not clearly understand the difference between that particular cure of which *similia* is the law and any cure that one can possibly attempt in rational practice. In the October number of the *American Medical Monthly* (Baltimore, Maryland) I discussed, in the light of accurate definition of that particular cure of which *similia* is the law, quotations from Brunton and from H. C. Wood upon the subject of homœopathy, and showed that neither of those gentlemen seems to understand even what is the cure of which *similia* purports to be the law. I propose to now discuss, in the light of that same definition, some remarks upon homœopathy by Frederick William Headland, M.D., B.A., F.L.S., Fellow of the Royal College of Physicians, etc., etc., in his famous work, *The Action of Medicines in the System*.\*

Before quoting what Headland says specifically on the subject of homœopathy I will quote something which he says earlier, on page 18 of his book: "Thus, for the proper perfection of medicine as a rational science, two things are in the main needed: the first is a right understanding of the causes and symptoms of disease; the second, a correct knowledge of the action of medicines. When our acquaintance with these two subjects is complete, we shall be able to do all that man can by any possibility effect in the alleviation of human suffering." It is perfectly evident that Headland regards rational practice as the *ne plus ultra* of medicine, which it is not. I think that the great majority of us homœopaths have as high a regard for rational practice as has Headland, but we do not regard it as the *ne plus ultra* in medicine; we believe that there is a cure which transcends the possibilities of rational practice, and that *similia* is the law of that cure. A definition of that

---

\* [Ninth American Edition. Philadelphia: P. Blakiston, Son & Co. 1882.] To the original draft of this Essay, here published in book form, the president, officers and fellows of the Medical Society of London awarded the Fothergillian gold medal for 1852.

cure is the following: *Such modification of the quality of vital processes and their effects that, whereas these processes and effects are abnormal, they shall become normal (or approximately so) as the immediate (i.e., not secondary) effect of the medicine used.* That cure (an immediate transformation of vital processes from abnormal to normal) cannot be attempted in rational practice, because the data to any rational practice must be in themselves knowable, and vital processes are not in themselves knowable—they are knowable only *in effects*. Evidently, then, that cure which we have just defined transcends the possibilities of rational practice. That particular cure can be intelligently attempted only under guidance of a law of nature, which law shall state what relation between diseased vital processes *as known in their effects* and a dynamic drug *as known in its pathogenetic effects* marks that drug as capable of effecting in some degree that cure. *Similia* is that law of nature.

When Headland comes (on pages 52 and 53) to speak specifically of homœopathy, what he says is perfectly consistent with his previously expressed view that rational medicine is the *ne plus ultra* in medicine. He does not even recognize any question whether *similia* may be the law of a cure transcending the possibilities of rational practice. He discusses *similia* as a “rule”—cites three diseases similars to which he thinks cannot be produced by drugs, and then says: “when such remedies are known, their employment would certainly be singularly objectionable.” These words last quoted are simply the expression of such an opinion as is perfectly in order when a question of rational practice is discussed, but is entirely out of order when considering a drug that is indicated by a law of nature; for (as is shown in my little book above named) an *a priori* reason from the standpoint of the individual is essential to any given rational practice, but *similia similibus curantur* (the *a priori* reason for the selection of any given homœopathic remedy) is not from the standpoint of the individual, but is one of nature’s laws, operations under which transcend the capacity of human reason. Does one reject the indications of the law of gravity because effects under it transcend the capacity of his reason? Does he say of measures indicated by the law of gravity that “their employment would certainly be singularly objectionable?” No! When one accepts the law of gravity he, for the

reason that "a law of nature is an ultimate fact," does not expect to understand how effects under it are operated. If *similia* is a law of nature, how effects under it are operated transcends the capacity of human reason, and an opinion that certain remedies indicated by that law "would certainly be singularly objectionable" is entirely out of place. Neither Headland nor any one else will ever understand homœopathy so long as he is preoccupied by the false opinion that rational practice is the *ne plus ultra* in medicine.

We have found accurate definition of that cure of which *similia* is the law useful in showing that Headland does not understand the subject of homœopathy. This definition is immensely useful in showing, too, that the homœopath can consistently accept whatever else than homœopathy is good in medicine. That the cure of which *similia* is the law transcends the possibilities of rational practice—that, in other words, homœopathy, in a sense, outranks rational practice—is good and sufficient reason why one who believes in homœopathy should identify himself by name with *it*; that he may first, last and all the time (whatever his practice in a given case may be) be known as an advocate of homœopathy—a defender of it against the attacks which the larger body of physicians feel called upon to make on it—against, indeed, their unintermittent hostility toward it. But when, in the light of accurate definitions, it is seen that the immediate end sought in any given practice of homœopathy is entirely different from any immediate end that can possibly be sought in rational practice, or intelligently sought in empirical practice, it becomes evident that there is no inconsistency in accepting homœopathy, and at the same time accepting whatever else than homœopathy is good in medicine. This whole matter is clearly set forth in my little book above named, which treats of homœopathy, rational practice and empiricism.

I close this article, as I did that in *The American Medical Monthly* above referred to, with two statements: 1st, I have never seen in print an adverse criticism of homœopathy which did not seem to me to betray a misunderstanding or a lack of understanding of the subject; 2d, I think an accurate definition of that cure of which *similia* is the law is essential to the most satisfactory exposition of the fact that a homœopath can consistently adopt anything that is good in medicine.



## THE HOMŒOPATHIC TREATMENT OF BURNS AND SCALDS.

BY JOSEPH C. GUERNSEY, A.M., M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Scranton, September 21, 1897.)

THE March (1897) number of the *Hahnemannian Monthly* contains a most excellent article on the "Picric Acid and Aristol Treatment of Burns."

Viewed from a surgical standpoint, the information given seems quite complete for the general practitioner. Burns are of such common occurrence that all obtainable practical knowledge of their treatment must be acceptable to the profession. But while surgical treatment of burns is a *sine qua non*, their therapeutics require careful study and application. To this end I desire to call attention to a valuable article by the late Dr. Lippe, published in the *Philadelphia Journal of Homœopathy*, vol. xi., p. 17, which is substantially as follows:

"Every individual case of burn requires its own treatment according to our law of cure (*similia similibus curantur*), and thus any remedy in the materia medica may be required in any given case of burn or scald, according to the symptoms.

"The following conditions are those most frequently found in general practice.

"Burns and scalds are caused when our bodies come in contact with fire, steam, heated substances, mineral acids, alkalies, or some of the metallic salts and oxides; and the degree of the ensuing inflammation depends, *a*, on the degree of heat; *b*, on the time (*i.e.*, duration) of contact; and, *c*, on the tenderness of the parts involved.

"We will confine ourselves to four degrees.

"1. Burns or scalds of the first degree are caused by steam or from the contact of more or less hot substances. They produce a deep, not circumscribed, redness of the skin without swelling, which vanishes when pressed upon by the fingers. The skin peels off in a few days. *Ars.*, *bell.*, *euphorb.*, *hamamelis*, *rh. tox.*, *tereb.* correspond with that condition of the skin. *Hamamelis* is the most efficacious remedy; the distilled preparation, externally applied, will reduce the pain immediately.

"2. *The second degree*, mostly caused by heated fluids, produces, either immediately or gradually, larger or smaller blisters filled with yellow or transparent fluid. The redness and swelling of the skin are more intense than in the first degree, pain is more severe—burning—and is usually accompanied by fever. In course of time the vesicles dry up, the fluid becomes absorbed, and the epidermis is thrown off. If they burst or are opened, and the fluid emptied, the blister sinks in and dries up, a new epidermis is formed, or the place suppurates. No remedy corresponds closer to this condition than cantharides, which, if applied early enough, will prevent the blisters from forming to any extent. If they have formed, the tincture of cantharides applied externally will soon relieve the pain. *Urtica urens*, creasote, causticum, come next in value to cantharides. If ulcers have formed, *ars.*, *carb. veg.*, *cycl.*, *lach.*, must be considered.

"3. *The third degree*, caused by the flames of fire or by longer contact of the body with hot substances, especially hot fluids, is characterized by gray, yellowish or brown spots, which are thin and soft, painless when slightly touched, but painful when more severely pressed upon. Blisters appear filled with a brownish or bloody fluid; the adjoining parts are red and much swollen. This condition corresponds with the symptoms of *ars.*, *canth.*, *cycl.*, *creas.* Weak creasote-water applied by wet linen cloths will generally soon allay the violent pain, or a weak caustic solution can also be used.

"4. *The fourth degree*, caused by long contact with fire, red-hot or melted metals, boiling fluids, etc., involves the destruction of the whole thickness of the skin and the cellular texture, or may even burn through the muscles to the bones, or may burn a part of the body to a coal. If there be intense burning pain in the injured part, whether ulcerated or not, arsenicum is the remedy. If the ulcers bleed, give *carbo veg.*; if the ulcers become gangrenous, give *secale corn.*, *caust.*, *cycl.*, *lach.* If the burn is caused by phosphorus, sweet-oil is the best remedy."

#### PATHOLOGICAL CONDITIONS FOLLOWING BURNS AND SCALDS.

Cases of severe burns always produce correspondingly severe constitutional disturbance, usually manifested by a severe congestion of some part of the body, as of the brain, with

more or less serous effusion. In like manner the lungs, or the abdominal viscera and kidneys, may become congested or inflamed, and cause extensive suppurative action. The period of suppuration is sometimes aggravated by venous or arterial hæmorrhages, and during this period the kidneys, the intestinal canal and the nerve centres are liable to irritative or inflammatory changes. The kidney changes are so constant that they may be expected and looked for in every case of burn of any magnitude. In all cases of burns and scalds involving any considerable extent of surface, where marked constitutional disturbance exists, the kidneys become congested or inflamed, and albuminuria is produced.

In even light cases of burn the presence of albumin may be detected, while in those very severe cases which prove fatal the albumin may amount to two-thirds of the bulk of the urine examined.

A fact worth noting, in this connection, is that the amount of albumin found in the urine after a burn or a scald is coincident with the temperature of the body. If the clinical thermometer shows no elevation of temperature, there is probably no albumin; in cases where the temperature is  $101\frac{1}{2}^{\circ}$  to  $102^{\circ}$  F., albumin is almost certainly present; and the graver the case and the higher the temperature the greater the amount of albumin will be present. It sometimes happens that for a time after a burn or scald the temperature remains practically normal, and no albumin can be discovered. But if the temperature rises and the specific gravity falls, albumin should be looked for and will probably be found. As the temperature recedes the albumin disappears. When the temperature rises to  $101^{\circ}$  F., the specific gravity is apt to be lessened, and albumin will be found; at a temperature of  $102^{\circ}$  F. the specific gravity is materially lessened, and albumin is quite sure to be found. In cases which receive fatal burns or scalds, albumin is present immediately. Examination by the microscope shows casts, usually epithelial, and blood corpuscles. The presence of albumin should be expected in burns and scalds of any severity, *i.e.*, those involving much extent or depth of the body.

Further pathological results of burns and scalds, besides acute nephritis, are intestinal catarrh, intestinal hæmorrhage, and ulceration of the stomach or duodenum; also erysipelas,



hæmorrhages, lockjaw. Laryngitis, bronchitis or pneumonia may also result from scalds or burns. The laryngitis is often produced by the inhalation of hot steam, while the bronchitis and pneumonia are developed by burns of the chest and neck.

Symptoms suggestive of brain involvement frequently appear after burns or scalds, and such complications, accompanied by effusion, do occur. But often the delirium or convulsions are merely the effect of traumatic shock or surgical fever; and it must be remembered that an uræmic condition, attendant upon a marked albuminuria, will many times explain the cerebral symptoms.

When a large amount of skin has been destroyed by a burn or scald, contraction of the part follows; and if the loss of tissue be in the region of a joint, its usefulness is much impaired.

Post-mortem examination of fatal cases of burns have, in some instances, shown hæmorrhagic nephritis.

Frost-bites and burns present so many visible similarities that it is interesting to state here that severe frost-bites, followed by elevation of temperature, cause albuminuria during the high temperature—just like burns.

In this connection of burns and heat, I desire to say a word about high temperature of the body in disease, and it is as follows: Elevation of temperature, or heat, is much overestimated as the damaging element in disease, while the *cause* of the increased heat is too much neglected. In reality, the increase of body-heat is only a *symptom* which requires the hygienic surroundings to be as perfect as possible, with plenty of fresh air, which should be kept in active circulation. The original disease-poison which causes the high temperature is largely eliminated from the system by the kidneys; and it is under such conditions as these, while the kidneys are striving to rid the system of an excessive amount of diseased and effete material (badly handicapped, meanwhile, by the fact of their receiving much less nutriment than in health), that they are liable to suffer irreparable damage. The application of cold to the body in such conditions as these is fraught with danger, and in many instances it undoubtedly develops a fatal kidney complication. In fact, it often happens that a cold pack or bath only serves

to increase the temperature and to produce albumin in the urine.

Cases of sunstroke repeatedly and thoroughly deluged with cold water to lower the temperature have been followed by the appearance of albumin in the urine, which increased more and more in volume until all the urinary symptoms of acute parenchymatous metamorphosis appeared.

---

## THERAPEUTICS OF CHRONIC BRIGHT'S DISEASE.

BY CLIFFORD MITCHELL, M.D., CHICAGO.

PROGRESS in the therapeutics of chronic Bright's disease is certainly slow, yet every year I feel that we make a certain gain. In my experience the problem of defense is to be solved differently, according to the character of the attack. It is convenient to classify the cases as follows :

- I. Cases of moderate intensity.
- II. Desperate cases.

### I. TREATMENT OF CASES OF MODERATE INTENSITY.

In the parenchymatous form such cases show moderate albuminuria (albumin 1 to 3 on the Esbach tube); dropsy is localized; dyspnœa not marked; stomach and heart not seriously affected.

In the interstitial form nervous and gastric symptoms are not severe, though nocturnal urination, chronic neuralgias, seldom severe, and increased tension are observed.

Whether the case of moderate intensity be parenchymatous or interstitial, climate, diet, hygiene, and the single remedy in the lower potencies (seldom tincture) constitute the treatment.

As regards climate, my attention has been called lately to certain advantages of Catalina Island, off the Pacific coast. One patient, whose chief trouble was insomnia, was greatly helped by spending the spring and summer there.

The drugs which, in potency, are to be used in the milder parenchymatous cases are numerous, but among them arsenicum and its iodide, apium virus, ferrum phos., and mere. cor.,

are too well-known to need comment. In acute intercurrent attacks, cantharides is not to be forgotten.

I have cured, so far as is apparent, several parenchymatous cases of milder intensity with Boudreaux's syrup of the protochloride of iron, or pills of the same preparation. This remedy works well with young people and women. Two cases in men between 20 and 30 years of age have apparently recovered under use of Hensel's Tonicum. One of the latter recently went through an attack of pneumonia, and, although enfeebled by it, shows no return of nephritic symptoms.

Lactate of strontium, as is well-known, will, in many cases, reduce the quantity of albumin. I have noticed that patients set great store by this improvement in quantity of albumin, so that the lactate should not be forgotten. The preparation of Paraf-Javal, is not likely to disturb the stomach.

A very flattering testimonial to the value of strontium lactate was given me recently by the speedy recovery of an elderly man on five-grain doses of the crystals. His symptoms were albuminuria of moderate intensity, weakness, and occasional attacks of vertigo. Various remedies were tried, without diminishing the albumin, but, under the lactate, he recovered speedily, and albumin diminished from 15 per cent. bulk, by the ferrocyanic method, to 2 or 3 per cent.

The cases of milder intensity are sometimes relieved by thorough flushing of the kidneys with various waters.

In the treatment of cases of chronic interstitial nephritis of moderate intensity, aurum muriaticum natronatum has time and again been effectual in my hands in diminishing the nocturnal urination. It should be given at first in the second decimal, and, before abandoning it, in doses of  $\frac{1}{50}$  to  $\frac{1}{25}$  of a grain of the crude.

Great benefit is obtained when the annoying urination at night is held in check. The patient sleeps better and gains flesh.

For the chronic headache of the milder kind, not so severe as to cause agony, but yet sufficient to make the patient miserable, glonoin, caffeine, and baptisia are the drugs. In my experience, caffeine is, on the whole, the best; but I have not yet had brilliant success with any drugs in the treatment of this obstinate condition. Nevertheless, under the continued



administration of caffeine, one of my patients is able to attend to his business, after months of misery and enforced idleness before this drug was tried.

Dr. Charles Gatchell, of Chicago, is an advocate of the use of plumbum in chronic interstitial nephritis. One of his cases in Cook County Hospital made rapid recovery under plumbum acetikum 6x.

Effort should certainly be made to cure with potencies, instead of crude drugs, for in nephritis much depends on keeping the stomach and heart intact, to say nothing of the bowels.

What, now, is to be done with the desperate cases? Here we have only secondarily to deal with the patient, for the patient's family and friends are the primary trouble. We find the latter completely demoralized, turning every which way in anxiety and distress, and likely, in their extremity, to become victims of the hordes of therapeutic pretenders who are besieging their gates and battering down the portals of their common-sense.

## II. THE TREATMENT OF DESPERATE CASES OF CHRONIC BRIGHT'S DISEASE.

After an unpleasantly extensive experience with moribund cases, in which I have been called in at the eleventh hour as consultant, I find myself by no means without hope. I am not so afraid of these cases as I used to be, provided I see them before the comatose stage.

The family demand that "something be done," and the "something" is not to be in centesimals. Dropsy must be reduced, the urine increased in quantity, the patient relieved of dyspnœa, and the heart strengthened, or, presto! the host of therapeutic pretenders has possession of the citadel.

Alternation of drugs in material doses is practically a necessity in these desperate cases, and actually saves life. I have no patience with nihilists and pessimists. If you know your pharmacy and your drugs, you can save a life or two now and then, instead of losing all or abandoning them to the Apaches.

What are the drugs which in alternation work well together, and sometimes save life? A summary may be given as follows:

- 1 When apocynum fails to increase the quantity of urine

and to reduce dropsy, alternate it with *aralia hispida* before abandoning its use altogether, with an occasional dose of magnesium sulphate to act on the bowels.

This treatment worked wonders in the case of a boy of 12 whom the writer saw as consultant, and in whose urine all the signs of chronic parenchymatous nephritis with fatty degeneration were present. Patient is alive and well to-day.

2 When *digitalis* is indicated but fails to relieve, give *adonis* in alternation. This I have from Purdy. Have tried it several times, thus far without success, but always bear it in mind.

3. In uræmic cases, after using *jaborandi*, follow up with *digitalis*. This treatment is, of course, not analogous to the preceding, yet it enables us to give the *jaborandi* with greater freedom. The latter is better given internally in small doses of the tincture every fifteen minutes than any other way.

4. Paraldehyde and caffeine are known to work well together. One of my colleagues has given me full notes of a desperate case, waterlogged and despairing, which he restored to comparatively good health by giving paraldehyde 40 drops at night hourly for three hours, followed next day by citrate of caffeine, 1 grain every four hours. This alternation reduced dropsy, relieved dyspnœa, and increased the urine, so that the patient is alive and able to attend to his business to-day.

5. In purely cardiac dropsies, *digitalis* sometimes works better when alternated with *cactus* and caffeine. In a case of this kind in which I was consultant from the renal standpoint, the dropsy was removed by the use of the three above-named remedies.

6. One of the most valuable alternations which I know of is that of *elaterium*, *apocynum*, and *strychnine*. In a case of an elderly man with chronic nephritis with dropsy, and also slight glycosuria, epsom salt irritated the stomach and weakened the patient. Diuretin irritated the stomach, even in the smaller doses. Infusion of *apocynum* seemed to irritate the bladder. Recourse was had to the following treatment: *Elaterium* was given in two tablets of one-tenth grain each at first, with a few hours' interval between each, in the morning; later two-tenths in the early morning; *apocynum* tincture three times daily in doses of 7 drops, after a time reduced to 3 drops; *strychnine*  $\frac{1}{100}$  of a grain night and morning.

The bowels moved freely eight to fifteen times a day under

the action of the elaterium, and great relief was experienced from subsidence of the dropsy. I examined the urine from time to time, and at the last examination the twenty-four hours' urine and urea were normal in amount, and but a trace of albumin and a hyaline cast or two left.

The patient is now on arsen. iod. 3x and kali mur., in addition to the other drugs when needed.

7. Diuretin will sometimes remove dropsy, when given in larger doses than the usual 60 or 75 grains daily. If elixir of pepsin be administered after each dose, as high as 120 grains daily may be given without affecting the stomach. This drug, however, occasionally aggravates the albuminuria and cylindruria, and its action should be watched.

8. In cases with cardiac complications, especially valvular, strophanthus is often the drug. It is, however, of but little value in purely nephritic cases. In many cases where strychnine in large doses,  $\frac{1}{100}$  to  $\frac{1}{30}$  grain, is now used without effect, I am convinced that strophanthus would prolong life.

9. Milk diet is a valuable adjuvant, but is often abandoned because the patient "cannot take milk." In the case of adults, mix Célestins Vichy one-third with the milk. For children, add vanilla extract to flavor and a little sugar. If this disagrees, try lime-water or Vichy, as above.

The only cases now left which really dishearten me are those in which such violent heart-action occurs that on entering the room the physician is at once aware of the pulsations. In one case which I saw, the pounding of the heart shook the bed. Every one of these cases has resulted fatally in from three days to a week. I have seen four in all, two children who died in a short time, and one man who died in a week; one woman (not nephritic) recovered from the cardiac trouble so far as violent action was concerned, but finally died from dilatation of the heart.

Spigelia, cactus, kalmia, digitalis, adonis, and merc. dulcis were tried ineffectually in these rapidly fatal cases. Merc. dulcis and Rubinat water, followed by cactus, caffeine, and digitalis, relieved the violent heart-action in the case of the woman, but as she was not nephritic the case does not really belong to our category. I earnestly invite the attention of the profession to these cases of nephritis, fortunately rare, in which violent heart-action is a feature.



## THE ACUTELY UNCONSCIOUS.

BY WESTON D. BAYLEY, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Scranton,  
September, 1897.)

ONE of the problems frequent in hospital work and occasional in private practice is the finding of a patient unconscious, with or without an injury, and often with no obtainable history, or with but scant information inadequate for diagnostic purposes. It is therefore of importance for us to have fixed in our minds certain diagnostic principles which can be promptly and methodically applied for the early interpretation of such cases.

The factors are sometimes simple and a correct conclusion is easily reached; sometimes multiple, and a diagnosis is difficult or impossible. The more difficult cases are usually those in which, in addition to unconsciousness, there is also a traumatism, and in these cases the vital question is, Did the trauma cause the unconsciousness, or did a primary unconsciousness cause a fall, with injury resulting therefrom? A correct solution of this problem is frequently the means of saving life. It is clearly the first step to get every detail and circumstance obtainable—often the slightest clue will serve in differentiation. The extent and character of the wounding may throw some light on the problem, but this cannot offer more than presumptive evidence. The presence or absence of paralysis or convulsion, the state of the reflexes, the condition of the pupils, the odor of the breath, the character of the urine, the temperature, the depth of the unconsciousness, the condition of the tongue (as to recent cuts and old scars), and the condition of the heart and arteries should be immediately noted, as it is by a proper consideration of these objective conditions that a diagnosis is to be reached.

I say proper consideration, because some of the evidence may be fallacious and misleading. For instance, the detection of an alcoholic odor may not mean alcoholism, because the drink may have been a coincidence, or else given as a remedial measure for some graver condition. Albuminuria does not necessarily imply uræmic coma, because Bright's disease is

often coincident with cerebral hæmorrhage; contracted pupils do not infallibly point to the coma of opium, for we often find such pupils in uræmia and other irritative brain conditions. Thus it is clear that the information derived from a consideration of but one symptomatic feature is only relative in value, and that consideration must be given collectively to all of the conditions which have just been mentioned. As a type of the difficulties referred to I condense the record of the following case:

Unknown man, about 65 years, brought in unconscious by patrol; an empty three-ounce laudanum-bottle in his pocket, and a contused wound of his left eyebrow; could be partially aroused, but his talk was incoherent and he immediately lapsed into stupor. Had this been all, the question would have rested between opium stupor and traumatic brain affection, without localizing symptoms. Perhaps we would also have considered post epileptic coma, meningitis, the apoplectiform signs of chronic insanity, and uræmic or diabetic coma. But he had a left-sided hemiplegia. This symptom aided in excluding some of the above-mentioned affections. Had he been poisoned by laudanum? Because of the circumstance of the empty bottle his stomach had been promptly emptied, without result. There was no odor of opium; the pupils were only moderately contracted. His wife, coming in opportunely, stated that he had been an opium habitue, and that he had emptied the bottle two days before admission to the hospital, and that the doses were no larger than he customarily took. At any rate, opium does not cause a hemiplegia, and even without the wife's explanation we would have looked elsewhere for an interpretation of this symptom, and that elsewhere would be his injury.

That the hemiplegia was not an old one we knew by the absence of rigidity and the fact that the knee-jerk on that side was not increased; also by the appearance of his shoes, which were equally worn. Now, did he by falling fracture his skull or induce a meningeal hæmorrhage? Or has this been a deep cerebral hæmorrhage, with a consequent fall and head injury? Or has the *contre coup* of a fall caused a hæmorrhage in or near the internal capsule? The process of reasoning in this case was:

I. If the hæmorrhage is cortical from head injury the lesion

must be large enough to take in the entire Rolandic region, because of the distribution of the paralysis.

II. Such an immense lesion would cause very stormy brain symptoms, deeper coma and more convulsive phenomena than the patient presented.

III. Is it not probable that there was some reason for his use of laudanum? Was it not most likely for relief of the headache of some vascular disease which is apt to terminate in cerebral hæmorrhage?

From the general facts here briefly stated it was believed that this man had a hæmorrhage in the right internal capsule, and that in falling he cut his scalp. A post-mortem verified this opinion.

Opium cases are comparatively common. When in coma they are completely relaxed, usually with snoring respiration, and pupils conspicuously small. In this state the patient usually presents a ghastly pallor. These finely contracted pupils are usually regarded as characteristic, but I have observed an equal degree of myosis in two cases of uræmic coma. Such pupillary contraction also is present in hæmorrhage into the pons, but this is usually rapidly fatal.

Patients are found comatose after having had a perhaps unobserved fit, and the diagnosis in this post-epileptic coma is not always as easy as it would appear. We may obtain evidence of convulsions by finding a scarred tongue. The color of the face, which is regarded as pathognomonic by some, is not to be relied upon.

The coma of uræmia, in the absence of history, can be excluded by urinalysis. But the converse does not hold good, for the presence of albumin and casts is clinically not oftener present in uræmia than in brain hæmorrhage. The two conditions can usually be differentiated, however, by the age, the pallor, the pulse (usually rapid in uræmia, slow in hæmorrhage), perhaps the difference in the degree of unconsciousness. In some we can detect in the breath what is called a "uræmic odor," which is considered diagnostic.

The apoplectiform attacks of paralytic dementia closely simulate cerebral hæmorrhage. In the several cases seen by the writer a differentiation would have been impossible without history or autopsy.



The coma of thermic fever is usually profound. Breathing is apt to be rapid and shallow, with a tumultuous heart-beat. Most cases seen by the writer have had alcoholic breaths. The temperature is always elevated,  $110^{\circ}$  being not uncommon.

In one instance, in July 1896, an axillary temperature registered  $111^{\circ}$ , and a case seen about the same time presented a rectal temperature of  $112^{\circ}$ . These temperatures were estimated by gauging the distance which the column of mercury rose above  $110^{\circ}$ , the highest marking on an ordinary thermometer. Both cases recovered.

The presence of sugar in the urine invites a suspicion of diabetic coma. In this there is a peculiar odor from the mouth which is described as "fruity." von Jaksch believes this coma to result from the presence of diacetic acid, and not to be diabetic at all in its etiology.

The coma of meningitis is usually the forerunner of death. In this there is a slow pulse, in contrast with a rise in temperature. Often a retracted abdomen, twitchings, rigidity of neck muscles, pupils contracted or dilated, strabismus.

Lastly, we have the perplexities of a common drunk, which are often by no means easy to unravel. The fact that liquor is given and taken as a universal panacea diminishes the significance of its detection on the breath or in the stomach. These cases often fall, and are cut and bruised about the head. Delirium tremens is frequently diagnosed off-hand, when another of the conditions already reviewed is present, masked, perhaps, by drink. Alcoholic coma is often very deep, and its diagnosis should never be left, as is usually done, to the primitive skill of the police. The stimulus of the faradic current is an aid in the diagnosis of alcoholic unconsciousness.

---

## THE TREATMENT OF ABSCESS OF SUPERFICIAL TISSUES.

BY D. P. MADDUX, M.D., CHESTER.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Scranton, September, 1897.)

It might seem that I should offer an apology, or at least an explanation, in presenting to this Society a paper upon a subject apparently so trivial, especially when I must preface the

paper by a statement, which you will probably verify later, that I have little or nothing to offer but what you are already familiar with.

Assuming, however, that you are all familiar with the correct and most successful methods of treating abscess, a fairly extended observation has led me to believe that in actual practice many yet follow the methods of what Pruden calls the "Pre-Bacterian Epoch."

My excuse for writing upon this subject is, that the treatment of abscess probably furnishes more surgical cases to general practice than any other single surgical condition; and if we consider its primary treatment as an operation, as it generally should be, it furnishes to the general practitioner more operations than all other surgical cases combined. For obvious reasons I cannot, in this paper, consider abscess affecting the organs in the interior of the body, or those affecting but few of the deeper tissues. I wish especially to consider methods of treatment of local inflammation and pus-collection in the subcutaneous and muscular tissues.

Abscess was defined, when I was at college, as "A circumscribed collection of pus," circumscribed by the time-honored "pyogenic membrane." For the present purposes it might be considered as a localized area of excessive bacterial development containing, in advanced stage, the products of bacterial life and the results of bacterial death, accompanied by more or less tissue necrosis.

I regard as a needless task the effort to demonstrate the causal relationship of bacteria to abscess. The invariable exhibition of their presence when adequate search has been made, the constant results of inoculation both in the laboratory and outside of it, have demonstrated bacteria to be the *sine qua non* of suppuration.

The problem, then, that presents itself is, how to destroy their power of further injury, and to overcome their effects in the easiest, safest and promptest manner.

It is manifest that an early recognition of the presence of pus is of the utmost importance; but before the formation of free pus, before the devitalization of tissues and the presence of what we term pus corpuscles, we have present in superabundance these identical bodies in the shape of leucocytes, these

leucocytes having fled from their home in the capillaries to suppress the riot of disorder in the surrounding tissues. Now, can we cure, or rather abort, abscess in this stage, when the severity of the heat, redness, pain and swelling indicate that suppuration is inevitable, unless prompt and efficient methods are employed? I mean when there have been no rigors, when there is no softening, no pointing, no boggy, doughy or fluctuating feeling—when it is hard, tense, and its exact outlines difficult to determine? Frequently we can. Generally, in minor cases, we do not see them until they are past this stage. To relieve this condition, first render the surface skin as nearly aseptic as possible. Formerly I scrubbed the parts with a solution of carbolic acid; recently I have been using, with better results and less discomfort to the patient, the antiseptic soap of Parke, Davis & Co., prepared from the formulæ of Dr. McClintock. If there is very decided sensitiveness I spray with ethel chloride, and rapidly and deeply puncture, sometimes in several places, with either a hypodermic needle or a sharp tenotome. I have in some cases taken several hypodermic needles, after sterilizing or soaking them in a solution of formalin, stuck them into the inflamed area, and permitted them to remain for a few moments, thus relieving the extreme pressure which is largely the cause of pain and its continuance a cause of necrosis.

In most cases it is further desirable to inject some agent to assist in the destruction of the germ. I have used solutions of carbolic acid, bichloride of mercury, boracic acid, iodoform, hydrogen peroxide and formalin, and have obtained the most satisfactory results with the two last mentioned, using  $H_2O_2$  in its full strength, and formalin, 1–100 to 1–500 of the 40 per cent. solution, from a few drops to the contents of a hypodermic, according to the size and location of the abscess. I then apply a large pad of moist bichloride gauze. If the pain should continue in severity, a solution of bichloride may be applied as a hot fomentation; or, if on pendant portions of body, the part may be entirely immersed in the hot solution.

If the method described is applied thoroughly and early, it will in most cases cause prompt relief of pain and a subsidence of the inflammatory process. But there are some patients with uncontrollable or hypersensitive nerves who resist the proper application of this treatment, electing to suffer much more in



the aggregate rather than run the risk of lesser pain deliberately inflicted. We meet this class, who almost seem to enjoy the suffering incident to disease, compared to the suspicion of pain incurred in operative procedure, although many patients of a non-excitabile temperament have assured me that the pain incurred was less than that they had been continuously suffering previous to the operation.

Threatened suppuration from bruise of soft tissue may sometimes be averted by the application of iodine and olive oil, equal parts; by belladonna ointment; or, if accompanied by abrasion of the skin, by a mixture of iodoform 5j and boric acid 3j. I have had several cases where the swelling, heat, pain and redness were promptly relieved by a dry dressing of eucrophen. In this preparation, I believe it is the iodine that is the potent factor.

In the treatment of the ordinary acute phlegmonous abscess, an early, deep incision, with moderate, not forceful, flushing of formalin solution, and a carefully applied antiseptic toilet, changed every twenty-four hours, is all that is needed; but I believe that in these cases it is advisable to use the sharp spoon of the irrigating curette, and pack the cavity with glutol. I prefer glutol for a pack in these cases, because one can pack it in with more ease and precision than is possible with the other antiseptic powder. In very small abscess I frequently use the funnel-shaped aural speculum to introduce the glutol into the wound.

The Hilton method of opening abscess has not in my hands been eminently successful; the healing has been more protracted, and the resulting cicatrix, although smaller, has been more depressed.

The purpose of incising an abscess is not alone to make an opening adequate for the immediate drainage of the liquid contents; it should be ample enough to gain free access to the abscess cavity, and sufficiently large to be insured against closure before the deeper tissues are entirely healed.

I want to emphasize, at the risk of tiresome reiteration, that it is our positive duty, in the treatment of all cases of abscess, to exercise all proper precautions to place the parts in as aseptic condition as possible, and personally I know of no way of rendering a septic wound aseptic except through the use of an-

tiseptic measures. The previous presence of pus and sepsis is no warrant for abandoning measures tending to abate them; it is rather an indication for greater care and more complete thoroughness, extending to the surgical cleansing of adjacent surface, as well as to hands, instruments and dressings. Because they may heal without this fuss and bother on our part is not good reason for abandoning measures which lessen danger and promote more rapid healing.

Another caution I do not deem amiss is against the habit of attempting to squeeze out, by the pressure of our fingers, the contents of the abscess cavity. If the cavity is small, put in a pair of dressing forceps, with closed blades, and open them, letting in, the while, a stream from the irrigator, aided by mopping of absorbent cotton. I believe it is a safe guide for the surgeon, "when in doubt as to the presence of pus"—*cut*. I consider we do our patients a positive injustice when we let them suffer on for the pointing, fluctuating, ripening of an abscess. An abscess is ripe for the knife as soon as pus forms, and it is our business to show the pus a way out; not to idly wait until it almost liberates itself.

Nature is an unrivalled nurse, but she is not always a good surgeon; her resources in the liberation of pus are confined to the pushing, tearing, bursting process—a bungling method compared with a clean incision. An early incision is of value in the prompt relief of suffering; in the shortening of the time of healing, by reason of the lessened tissue necrosis and burrowing; in decreasing the risks of pyæmia and metastatic infection from pus absorption. Early incision need not be so extensive, and the consequent cicatrix and impaired function will be less marked. My own guide in the incision of an abscess is to make the incision nearly correspond with the base-line of the abscess cavity, it being desirable, of course, to incise in the line of the muscle-fibres and in the most dependent portion. Exception, of course, should be made to this, in some cases resulting from superficial cellulitis, where it may be desirable to make two or more incisions. But in diffuse cellulitis the most liberal incisions, extending right through the inflamed area, should be made. The longer an abscess has existed the more the need exists for vigorous curettage, and, where due to the breaking down of a gland, the entire gland should be scooped

out, with as many of the affected neighbors as is necessary. I use for this purpose the sharp spoon of the hollow-handled curette, with water running through it. As indicated before, I have a decided preference for a solution of formalin for washing abscess cavity. After curetting and washing I pack glutol into the cavity, cover the part with a layer of iodoform gauze, and apply over this an abundance of cotton, leaving the dressing unchanged for twenty-four hours. At the second dressing, if there is much discharge I again curette, and if there is much burrowing use a copious insufflation of some antiseptic powder, inserting into the cavities a piece of glass tubing or a soft rubber drainage tube attached to a powder-blower. I prefer for this a mixture of one part iodoform to eight of boric acid; then I introduce a large-sized drainage tube, puncture well, and lay—not pack—a small piece of gauze in the orifice. Unless one is positively certain, in an abscess burrowing between different muscles, that the gauze pack reaches all parts, better results are obtained by covering the parts with antiseptic powder and depending on drainage tubes. I may speak too enthusiastically of this method, as I have not yet used it on many cases, but in several very severe cases, two of which burrowed to the muscular attachment of the femur, the results obtained were highly gratifying.

I am confident that the granulations are often injured by the direct pressure of continuous packing; after an abscess is opened they need pressure from the outside to glue together the parts, and very little continuance of the pressure from the outside, of which they have already had an excess. When the entire abscess cavity is covered with healthy granulations, all slough having disappeared, we can shorten the time of healing and substitute a linear for a depressed scar by drawing together the edges with stitches. I have obtained exact coaptation in this manner two weeks after the incision.

An ideal plan with some cases of chronic abscess, particularly applicable in cases of scrofulous gummata, is the careful dissecting out of an abscess—as one would say, “cystic tumor.” In these cases suspicious portions of skin should be fully excised, and a clean wound may be left which unites by first intention.

As a wash for abscess cavities, I believe that formalin solution is superior to any other antiseptic we possess. I use it in



strengths of 1-100 to 1-1000. Formalin has none of the albumin-coagulating, instrument-ruining, toxic properties of the chloride of mercury. Carbolic acid, aside from its odor, which to some is sickening, will produce headache, giddiness, and, in some patients with weak heart, positive collapse; and it has an objectionable action on fresh blood-clots, causing an excessive oozing of an excellent culture-medium. Hydrogen peroxide, and its more powerful relative, hydrozone, have certainly a delightfully prompt effect upon the products of suppuration, but it has been my experience that their effect is transient; they exhibit considerable smarting, and their present cost prohibits their use as flushing agents. The results of formalin are more enduring. It seems to positively destroy and render inert almost all germs; in proper solutions it is non-toxic; it leaves no permanent odor; it does not injure the hands, steel or nickel instruments. It does have the effect of hardening tissues, and if applied to them continuously for more than forty-eight hours, as on moist gauze, it may cause slough. I believe it is but rarely desirable to use it as a gauze dressing. It is not desirable, if the abscess cavity is large, to leave in it any of the formalin solution; in fact, it is desirable to keep any wound as dry as possible, for germs cannot grow without fluid, and positive harm is often done by excessive washing after all need of irrigation has passed away.

If I have omitted reference to the use of poultices in the treatment of abscess, it is because for a dozen years I have found at no time any benefit, relief or use from this microbe incubator which in any way compensated for the pernicious tendencies it created.

The homœopathic therapeutics of the treatment of abscess should be included, to make this a complete paper: but on this score the individual case with its individual characteristics must, of course, be your guide; but while I fully appreciate the value of the proper prescriptions in the prevention of the formation of abscess, and while they doubtless aid in the reduction of the inflammation, I beg of you do not try unaided to open an abscess, and dress it, after it is open, with little pills.

However, this makes no pretense to be a complete paper; it merely gives some of the writer's individual methods, with the hope that if you have better ones you will let us know them.

## GELSEMIUM SEMPERVIRENS.

BY EDWARD CRANCH, PH.S., M.D., ERIE, PA.

(Read before the Homœopathic Medical Society, of the State of Pennsylvania.)

A WELL-KNOWN modern sacred writer, seeking a clear comparison for the insidious evils of life that we are all, alas, too prone to favor, likens them to "sweet poisons that kill, and flowers beautiful of aspect, concealing deadly venom in their beauty." If we wish to go on and name a specimen of this lethal class we will easily find, high in the list contesting for so doubtful an honor, "*Gelsemium Sempervirens*," the yellow jessamine, or jasmine, a favorite of Southern gardens. It is of charming beauty, and of heavy, almost narcotic but wholly delicious perfume; yet to chew its twigs or roots, or to drink of its infusion, will easily occasion sickness and death—a quiet death, with paralysis of motion, respiration and circulation; rarely with convulsions, or with premonitory loss of consciousness.

It is said to owe its introduction into medicine to its accidental, almost fatal, substitution for the root of another desired plant, in a case of bilious fever—the fever wholly disappearing after recovery from the acute poisoning by the gelsemium. It was first widely-introduced to the notice of the profession by E. M. Hale, in a "Monograph on Gelseminum," published in 1862. The correct spelling of the name was adopted later, and more was written about it in the several editions of "New Remedies," by the same author. The plant was also well studied by Roberts Bartholow and other authorities on *materia medica*. Of late it has grown with all desired speed in professional esteem, being used by all schools, in great variety of dose, and to fulfil a variety of indications. To-day its name is as familiar as that of aconite, and in frequency of use it outranks it, and closely rivals those giants of the *materia medica*, mercury, nux vomica, bryonia, belladonna, cinchona, arsenic, iron and pulsatilla.

Full doses of gelsemium act promptly on the healthy and on the sick, and either death or recovery follows in a short time, in a few hours or days at farthest, and there is little or no

chronic action. In short, it is a typical "kill or cure" remedy. Women are more susceptible to its action, as a rule, than men.

There are caused, by its action, severe pains in eyebrows and eyes, dropping of the lids, even paralytic ptosis, with more or less drowsiness, pallor, chilliness, and general prostration, so that the voluntary muscles cease to obey the will, with special weakness of forearm and leg and relaxation of sphincters. Then there is a mistiness of sight, with blindness or double vision, and occasionally deafness; painful vacuity of mind, but not unconsciousness; then paralysis of respiration and of circulation, with fear and alarm, not for the future, as with aconite, but for the present. Prostration increasing, death may quietly ensue, unless prevented by the timely use of stimulants, such as alcohol, ammonia, camphor, morphine or electricity, all which are antidotal to gelsemium. If death has not closed the scene, the reactive or secondary symptoms come on; the chilliness gives place to moderate but continuous fever, and this may again be replaced by profuse sweat, breaking up the fever. The torpor and the muscular relaxation change to irritability and jerking of single muscles, or to tetanic strain of sets of muscles, or rarely, to clonic convulsions; the relaxed sphincters become rigid; the drowsiness becomes wakefulness, accentuated by an itching, sometimes eruptive, on the face, neck and shoulders. The pallid cheeks become flushed to crimson; the nose, mouth, throat and chest feel dry, and there may be coryza, tonsillitis and bronchitis, associated with aching over the heart, and soreness of the abdominal walls. There are also numbness of the tongue, awkward speech, dysphagia and nervous cough. When the heart is weak the patient feels that he must keep moving to keep it going. (Exactly the reverse happens with digitalis; then the patient dreads the least motion, lest the heart should stop beating.) There is no tingling or prickling of the tongue, as in aconite, and the dryness is more a sensation than an actual condition, such as is found, both subjectively and objectively, from belladonna. The gelsemium subject suffers little or no thirst, and the restlessness, if present, is more in the nervous feeling than in actual motion. The pulse becomes fuller, softer, and, perhaps, intermittent; the capillaries become engorged, even inflamed, and passive congestions, or apoplexies, follow. In any stage a



staggering, drunken vertigo assails the subject if he attempts to move, just as his thoughts evade all efforts at prolonged concentration. The sexual sphere is weakened, and impotency and cessation of function are events in the action of gelsemium. Enuresis, or dribbling of urine, may be left as an effect of relaxation, while, if given in labor, it may arrest pains and retard progress, first by weakness, then by the reactionary rigidity. There are soft, yellow stools and occipital pains or dulness.

Such is the pathogenesis or story of the symptoms caused by the drug we are considering in varying doses, but mostly from the fluid extract in officinal portions, five to twenty drops, repeated every one or two hours till effects are manifest. The smallest fatal dose found on record was fifteen drops of the tincture, in an adult, or the chewing of an uncertain amount of the root by two children. The largest dose from which recovery was secured (by the free use of stimulants) was estimated as between a half a pint and a pint!

We will now consider the homœopathic action of the same drug by recording, with comments, its most characteristic symptoms, which justly deserve the name of "key-notes," since any one of them will serve to suggest the administration of gelsemium (in a sufficiently small dose to avoid unpleasant aggravation).

*Fever Moderate, but Nearly Continuous, with Fretfulness or Erethise.*—(A combination of excitement and prostration.)

(Suggestive in epidemic influenza or grip, in commencement of typhoid or other continued fevers, in dentition, in tuberculosis, and in convalescence from several disorders.)

*Chilliness, with "Goose-Flesh" Appearance of the Skin.*—(Found in those who take cold easily, are easily fatigued, and as a prodrome of intermittent or other fevers. It is generally associated with an indefinable feeling of illness, sometimes with shivering or chattering, as often happens before or after labor. This generally passes off without treatment; but in intermittent fevers of simple type, especially when the chill comes, as it sometimes does in the afternoon or evening, the drug is exceptionally valuable.)

## THE CAUSES AND PREVENTION OF URETHRAL STRICTURE.

BY L. T. ASHCRAFT, A.M., M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Scranton,  
September 21, 1897.)

SINCE stricture of gonorrhœal origin is so frequently treated by the general and special practitioner, it is that variety of which I shall speak. It may be defined as a lessening of urethral dilatability accompanied by structural changes in any or all of the tissues forming its walls.

Looking over the subject in a superficial way we see that it is usually the result of a badly managed acute clap which has become chronic, several factors being responsible. The urethra in advance of the compressor urethra and surrounding the bulb is abundantly supplied with glands and follicles, a favorite site for the inroads of gonococci and other pyogenic organisms. Urinary conditions subject to changes resulting from dietetic errors also predispose to irritate an already congested canal. The tissue changes will perhaps be better understood by quoting Finger of Vienna. The opinions advanced are the results of ante- and post-mortem findings, both macroscopical and microscopical. Hyperæmia, serous swelling and infiltration are revealed by urethroscopy. The epithelium rarely suffers to the extent of erosions, although in some superficial areas are observed. Marked thickenings and whitish discolorations exist. Circumscribed spots on the surface of the sub-epithelial tissue present uneven nodules, which by microscopical examinations prove to be granulations. The openings of the lacunæ of Morgagni are enlarged in some, and in others replaced by milky-white nodules imbedded in the mucosa. Occasionally erosions and papillomata obstruct the field. The most interesting observations, however, are disclosed by microscopic research. The upper layer of the cylindrical cells of the epithelium in most cases undergo mucoid degeneration. The transition cells occupy a larger area than usual. Pavement epithelium predominates. In the sub-epithelial connective tissue the inflammatory process produces most important changes, consisting of an infiltration of the con-

nective tissue resulting in retracting tissue. In new cases this infiltrate occupies the upper layers of the sub-epithelial connective tissue. Sometimes the cavernous body is involved; in other cases the cellular infiltrate contains new bloodvessels, both of which give the sub-epithelial connective tissues that papillomatous aspect termed granulation tissue. These granulations are flattened by retraction and a callosity results. The lacunæ exhibit changes similar to those found in the mucous membrane, producing in some dilatation of their lumen; in others, if retraction occurs, atrophy results. Where the corpus cavernosum is involved, Littre's glands are the seat of changes amounting sometimes to destruction. The corpus cavernosum is frequently attacked (although in some cases remaining intact) in two ways: first, by the chronic infiltration remaining superficial, entering along the excretory duct and around the bodies of Littre's glands; second, where the chronic infiltration occupies the entire thickness of sub-epithelial periurethral tissue, penetrating the corpus cavernosum, it remains either superficial or occupies its entire width. Where the circumscribed infiltration has undergone retraction, the mucosa and corpus cavernosum are converted into a firm retracting callosity. These deep-spreading callosities are the cause of stricture. To recapitulate: Granulation tissue is the result of long residence of the virus of gonorrhœa in certain areas of the urethra, and by its conversion into cicatricial tissue stricture is formed. Practically, how can we prevent this? The problem logically rests upon the treatment of chronic urethritis, its prevention, and, when established, its eradication. Let us briefly mention some methods employed for its prevention. In March, 1896, I had the honor of reading a paper before the Homœopathic Medical Society of the County of Philadelphia on the treatment of "Acute Specific Urethritis," entering a plea for its abortive treatment. The methods therein advised are now followed by those connected with the genito-urinary department of the Hahnemann Hospital dispensary. Several important measures have since been added. The well-selected internal remedy is assigned its proper place. Particular attention is paid to local treatment.

Nitrate of silver is valuable because it destroys gonococci, and although this drug has been abused, nevertheless, under



the following conditions, its action is prompt. A 4 per cent. solution should be used during the first twenty-four hours of the first attack; afterwards every second day until the discharge is free from gonococci. Although it may be administered by the simple-injection method, yet it is more successfully applied through an endoscopic tube. The drug suited to most cases is permanganate of potash, although its action is not so oxidizing as peroxide of hydrogen. It may be applied by the simple-injection method—strength, half a grain of the drug in half an ounce of water—although more satisfactory results have been obtained by continuous irrigation. At the Hahnemann Hospital dispensary we have always been ardent advocates of this method, and recently our enthusiasm has increased since using the Valentine apparatus. A brief description may be interesting. It consists of a conical percolator having a capacity of 36 ozs., with a rubber tubing 12 feet long and  $\frac{3}{8}$ -inch in diameter attached to its outlet. The proximal end of this tube is passed through a glass shield, a stop-cock is attached, and a glass injection-syringe inserted; a notched bar on the stop-cock regulates the force of the stream. The percolator is bracketed to a frame on the wall, and by means of pulleys can be elevated to a height of 9 feet. With this the posterior urethra and bladder may be flushed by overcoming the resistance offered by the compressor urethra, but they are left intact by pressing firmly with the little finger at the peno-serotal junction. The hydrostatic pressure afforded balloons the urethra, establishing an artificial œdema—an unfavorable soil for the life of the gonococci. Treatment should be given every morning and evening, using a solution of permanganate of potash of 1-1000. Valentine washes the bladder in acute anterior urethritis. This we refrain from, since there have been recorded several cases of infection when such a plan was adopted. Bichloride of mercury is valuable because of its germicidal properties; it should be employed in a solution of 1-20,000, using continuous irrigation. If a chronic state results, stricture is probable, and although the time elapsing from an acute gonorrhœa to stricture formation is rarely less than twelve months, yet within a shorter period granulation-tissue forms. How can we cure chronic urethritis? Our first duty is to ascertain what portion of the canal is con-

cerned in the morbid process by analyzing the well-known symptoms occasionally present, employing the two-glass urine test, using sounds, and by urethroscopy. Frequently no subjective symptoms accompany this condition, and usually the diagnosis is made by the other methods mentioned. The two-glass test, while not an infallible guide, is a most useful one. Pus formed anterior to the compressor urethra flows outward from the meatus, and is prevented by this muscle from returning to the bladder. That formed in the posterior urethra flows backward. Now, if the patient urinates in two glasses, the first will represent a portion of the bladder-contents plus washings from the urethra. The other will be clear, unless cystitis or kidney disease exists. If these are absent, and there is pus in the second glass, it indicates a posterior urethritis. A sound is of course useful in locating diseased areas. Frequently, however, satisfactory results are only obtained by endoscopy.

Chronic urethritis is very difficult to cure, even after thorough measures have been employed. Without doubt, the proper method is to direct local treatment to the diseased area; of course, at the same time, instituting such measures as will allay urethral inflammation. Sexual and alcoholic excesses should be positively interdicted. Occasionally we will meet with a variety of chronic urethritis where the canal is in a condition of catarrhal inflammation, the discharge being quite profuse. In such cases we should irrigate morning and evening with a solution of 1-1000 of permanganate of potash or 1-5000 of nitrate of silver, until the discharge becomes mucoid. Sometimes an underlying constitutional disease may have to be corrected before the case is cured. Ordinarily, however, the majority will present no symptoms except a morning drop or a gluing together of the lips of the meatus. The first therapeutic measure of importance that should be instituted is the passage of a sound; the size selected should comfortably fill the meatus, which, if too contracted, should be cut. The operator should make the incision upon the floor of the canal, postponing deep urethral treatment until the wound heals. The passage of a sound is beneficial, because it hastens the absorption of inflammatory products and expresses the contents of the glands and lacunæ, thereby exerting a curative action on the

pyogenic process. In the absence of urethral fever, a sound should be passed every third day. Following each instrumentation, the urethra should be irrigated with a 1-5000 solution of nitrate of silver. One of the most satisfactory measures at our command for treating the lesions found in chronic urethritis is by the use of the endoscope. With it diseased areas can be touched with very powerful solutions. Applications should be made by means of a cotton swab wound around the end of an applicator which has been previously dipped into a solution of either nitrate of silver, grs. 60 to the ounce, or iodine, grs. 60 to the ounce. This procedure should not be repeated until all inflammatory reaction has entirely disappeared. During the time elapsing between the passage of a sound or the employment of endoscopy the urethra should be daily irrigated with some antiseptic solution. By following these measures we should cure most cases of prolonged urethritis, and naturally (where the inflammation has not existed too long) prevent stricture. No case should be pronounced well until the following conditions have been satisfied: When no complications, such as involvement of other organs, exist, and when an injection of nitrate of silver fails to show gonococci in the discharge that it produces.

---

**ŒDEMA IN FRACTURES.**—In all cases of fracture of the lower limb Bloxam looks out for œdema, and directly he finds such to exist he looks to see if any pressure has been applied on the veins either by the bandages or by the limb being improperly slung. By this point we see that indirectly a tight bandage may either cause delay, impair, or absolutely prevent union.—*The Hospital*.

**SPRAINS AND THEIR TREATMENT.**—Graham defines a sprain as a wrench or twist of a joint—a sudden, partial displacement of two articulating surfaces, followed by immediate replacement. The symptoms include pain, swelling, discoloration, and usually heat, with impaired mobility. The diagnosis may be obscured by swelling, which may conceal also a fracture of bone. Whatever will quickly reduce the heat, the pain, and the swelling—such as massage, snug bandaging, and an elevated position of the joint—will proportionately make the diagnosis easier. The means just mentioned are therefore valuable not only for diagnosis, but also for treatment, and their use in many cases of sprains of all degrees of severity shows that recovery follows in one-third of the time required under absolute rest and fixed dressings without massage. Even the condition of a sprain involving a joint previously weakened by malignant disease may be rapidly ameliorated by massage, and useful motion be gained before amputation.—*Boston Medical and Surgical Journal*.



## EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

## MALE OR FEMALE.

A REMARKABLE vision is that called up before our mind's eye by the reports from Vienna of the crowds of ladies, on foot and in carriages, streaming to the office of Professor Schenck to learn from him how to become mothers of male children. The sight is in one way comical enough, and shows that the days of the baby-bearing stork are numbered, but it is not wanting in tragical elements. We may laugh, perhaps with a furtive tear in our eye, at the woman of fifty or sixty, pushing along with the throng of eager younger ones to learn the great secret, but the thought of the many whose whole earthly happiness may depend upon their ability to present male heirs to irrational husbands must fill us with pity.

Unfortunately it seems as if here, as in the case of Koch's tuberculin, the discovery has been exploited too soon, even before it had been substantiated by observations enough to remove the results beyond the line of coincidence. Newspaper enterprise is, alas! only concerned in creating a sensation. We trust that Professor Schenck may not be led to depart from the stand he has taken, not to give out his theory without facts to support it, no matter how many poor little girl-babies are being born in the meanwhile.

The possibility of the discovery of some means whereby the determination of the sex of offspring shall be within our reach can hardly be denied. It is determined in some way by Nature, and according to law, and we have therefore a definite object of search and investigation. Where it is supposed to be the result of supernatural interference, irrespective of natural laws, such search must at once be regarded as hopeless.

Even if the germ-cell does contain in itself the sex element, it can only be as a sort of tendency or disposition; and how often this is modified during its subsequent development is shown by the many abnormal results—monstrosities, her-

maphrodites, etc. If we would learn to influence the production of sex at will, we must seek, in the first place, to find out what factors are active in nature in producing the sexual differences, and when they cease to be operative.

In doing this hitherto, it has been too much the course to take for granted that the sexual difference lay in the germ-cell, and attention has been almost exclusively directed to the parents at the time of conception, and all the circumstances attending that have been noted and compared, and unreliable and varying conclusions have been reached. Witness the numerous "well authenticated," "well proved," "always reliable" methods put forth from time immemorial.

Sex is an accident. Herewith we intend only to say that the determination of sex takes place after conception, and is due to modifying influences brought to bear upon the impregnated ovum through the mother, and is not dependent upon any unalterable sexual characteristic inherent in the germ-cell.

If we trace the origin of sex back into the lower forms of vegetable life, it will be seen that they warrant the conclusion that preponderant anabolism and katabolism are the ruling characteristics of female and male organisms respectively. (*Evolution of Sex*, Geddes & Thomson.) The comparatively sluggish, more nutritive, preponderatingly anabolic cells are female; the more mobile, more exhausted, and preponderatingly katabolic cells are male.

Experiments made with plants and insects (Yung, A. von Planta, Eimer, Von Siebold), corroborated also by observations of higher animals (Girou, Düsing), and even of the human species (Ploss), in accordance with the above, would seem to justify the conclusion that "such conditions as deficient or abnormal food, high temperature, deficient light and moisture, and the like, are obviously such as would tend to produce a preponderance of waste over repair—a katabolic habit of body, and these conditions tend to result in the production of males. Similarly the opposed set of factors, such as abundant and rich nutrition, abundant light and moisture, favor constructive processes; that is, make for an anabolic habit, and these conditions result in the production of females."

The discovery of Professor Schenck, so far as can be judged from the meagre accounts of it which have been allowed to

reach the public, seems to be a practical application of these principles. As correlated facts, which the professor seems also to have made use of, is the relatively larger number of red blood corpuscles in the male than in the female, which number is capable of modification by diet, exercise and massage.

The opposing views advanced are, in the main, founded upon the belief in the inherent sexual determination of the germ-cell, a belief which is by no means universal, and which seems by analogy at least to be contradicted by the asexuality of unicellular organisms. Whether the germ-cell be bisexual, as Professor Schenck is represented as maintaining, or asexual, as seems to us to be more logical, in either case the possibility of practical economic as well as scientific good arising from the present agitation of this subject along these lines must be conceded by all. Further developments will be awaited with interest, and we hope with patience—even by those contemplating marriage.

---

#### A PHYSICIAN'S PROPERTY.

FROM one of our exchanges (*The Peoria Medical Journal*) we learn that “the Supreme Court of the State of Illinois has rendered a decision in the case of Dr. J. N. Dixon, of Springfield, who refused to testify in a personal injury case against the city of Springfield unless he was paid a reasonable fee for his service, claiming that his professional opinion was his own property, and could not be taken from him except by due process of law, as provided in the State constitution. Judge Creighton ruled against him, and fined him for contempt of court. The court held that his professional knowledge was not property within the meaning of the constitution, and that in the exercise of the right of the court to summon witnesses and compel them to testify no distinction could be made between kinds of knowledge.”

It would take drastic measures to purge us of contempt of a court which could hand down such a decision, and then, we are afraid, the purgation would be ineffectual—the symptoms alone would be suppressed.

First, an *argumentum ad hominem*. Would the learned judge hold his own legal knowledge in the same estimation? Would



he be willing to decide that a judge, or even a lawyer, could be compelled to give a judicial or legal opinion without a fee? We trow not; and yet in what does their special knowledge differ from the special professional knowledge of the physician? We all know how determined the legal examiners and cross-examiners are to have facts and not opinions, and we grant that any one, be he president, governor, judge or physician, possessing any facts bearing upon a case, should be compelled to testify to them; but when it comes to professional knowledge and opinions, the result of study, of mental effort, rendered possible only by an outlay of money and time, we fail to see how a property-right in these can be denied.

What is the property of a physician as physician? Is it only his real estate (if he have any besides what he carries around with him on his buggy-wheels), or his books, or his instruments, or his ox, or his ass? Is it not rather that which he has acquired with the greatest toil and expenditure of energy—his knowledge? Has he really any other “stock in trade?” Are not all else merely accessories? Should not, then, the opinions he may have formed, based upon this knowledge, be equally regarded as his own exclusive property? Should they not, indeed, be looked upon in a court of justice as, in a sense, “expert testimony,” since they can claim to be derived from special study of a special subject?

We fail to find in any of the definitions of the word “property,” given in the *Century Dictionary*, anything which could be construed as excluding professional knowledge or opinions.

There seems to us to be a growing tendency on the part of the legal profession in some quarters, while strenuously upholding their own, to curtail the rights of the medical profession, and to minimize the value of its services. It is no doubt due, in a measure, to the intangible nature of so many of these latter that this is the case. Several instances have been published of late where the seemingly exorbitant fees of lawyers were allowed by the court, while the more modest charges of physicians were unsparingly pared down, although health and life were at stake in the one case, and only dollars and cents in the other.

Although we hope the case cited above is only an instance of Illinois justice, and one which would hardly be possible in

our own commonwealth, yet in view of the fundamental regard for "precedent" which characterizes the legal profession, and upon which, indeed, it is based, it might be repeated even here, and if there is anything in the laws of Pennsylvania which could render such a decision probable, or even possible, it would be well for our medico-jurists to seek to have it altered.

**A FEW CARDIAC REMEDIES.**—Prof. Duncan, amongst heart-remedies, cites *convallaria mayalis*, which he prescribes in hypertrophy of the right side of the heart, with palpitation, angina pectoris, and intense migraine of the right side.

The distressing attacks generally follow muscular exertion and are succeeded by a weak and irregular heart-beat, with venous stasis.

*Strophanthus* has a different action, and is serviceable in patients with slow hearts but who suffer from palpitation; as, for example, in drinkers, where this drug may even destroy the desire for alcohol. I cannot say that I have ever seen this drug to act well in those with brachycardia. I find the iodide of potash, strychnia and the arsenite of copper to act better in those subjects who are generally arterio-sclerotics and old persons, usually with kidneys in a damaged condition. In such cases intestinal antiseptics, with charcoal and the arsenite of copper, will sometimes do more than a heart-remedy. The liver should be kept in fairly active condition, for as soon as the bowels become sluggish the patient bloats and commences to complain. A mild hepatic cathartic, with the arsenite of copper and possibly carbo veg. in appreciable doses, will soon straighten these cases up, if there be any such possible. I now have such a case under observation who does well under these measures, while with all my treatment with heart-remedies, pure and simple, he grew steadily worse. The dyspnoea in these cases is frequently intense and very distressing, even going on to syncopal and spasmodic attacks—bradycardia with epileptiform attacks (Stokes-Adams disease). Huchard calls it "dyspnée potomainique," and in that name lies the key to treatment.

*Kola* suppresses the desire for food and prevents muscular fatigue; but, secondarily, it produced grave myalgias of the heart-muscle in the provers. Therefore, it may be employed in the myalgias of bicyclists, athletes, etc. This drug resembles arnica, and it deserves to be better proved.

*Acetic acid* accelerates at first the heart's action, and later slows and weakens it. In dropsy it is like digitalis in its action, which it follows very well.—*Journal Belge d'Homœopathie*, vol. iv., No. 5.

**POISONING BY CALOMEL.**—Dr. Camescasse records a case of poisoning by small doses of calomel, which was observed in a patient with a heart disease. There first appeared a sensation of burning all over the body, which was rapidly followed by an intense erythema, with painful swelling, and, later, repeated desquamation.—*La Semaine Médicale*, No. 60, 1897.

Intolerance to the salts of mercury is by no means rare. The soluble salts are prone to cause erythema.

## GLEANINGS.

---

THE CLINICAL SIGNIFICANCE OF THE DISCHARGES IN INFANTILE DIARRHŒA.—In a paper upon the above subject, Dr. William E. Darnall, Atlantic City, N. J., gives the following classification of infantile diarrhœas, with the clinical characteristics of each. In this classification, based upon the gross appearances of the stools, he recognizes four principal types, under which may be included practically all varieties of the so-called "summer complaint." These are the (a) mucous, (b) the serous, (c) the pasty-white or musty, from its odor, and the dyspeptic; subdivided into (1) acid and (2) alkaline.

(a) The mucous stool, whose appearance is familiar to every practitioner, presents a discharge usually small in amount, frequent, and characterized by whitish, ropy mucus of a gelatinous consistence. It may be faintly streaked with blood or stained with fæces. Some authors have attributed the presence of this stool entirely to nervous disturbance of the secretive functions, presided over by Meissner's plexus, in the gut. As a matter of fact, this discharge is frequently associated with the nervous derangements of teething, and is frequently found in the children of families of distinct neurotic tendency. While this may all be true, it is equally true that this stool, in a large number of cases, is the result of errors in diet, and where no neurotic tendency can be made out.

The secretive function of children being more active than in adults, the delicate mucosa of the bowel finds itself more susceptible to the influence of local irritants. Over-secretion thus, with an abundant outpouring of mucus, is easily produced. This mucus may come from the whole alimentary canal or from any part of it. It is a matter of some importance, too, to be able to locate just what area it does come from.

In dysenteric states, where the colon is affected, the appearances are somewhat different from those described. Instead of mucus streaked with blood, there may be quite a bloody stool, and sometimes a stool known as hæmorrhagic, which consists almost entirely of blood. There are also much tormina and tenesmus, and the pain rapidly exhausts the little patient if it is not relieved.

Should ulceration be present, it may be determined by the occurrence in the discharges of pus and shreds of necrosed mucous membrane, in addition to blood and mucus.

(b) *Serous Diarrhœa*.—These stools are represented by copious watery discharges, which hardly stain the napkins. It is termed choleric diarrhœa, or cholera infantum. Associated with such stools may be severe vomiting, and usually a profound state of collapse. The severe shock under which the little patient labors is ascribed, on the one hand, to heat-exhaustion, on the other to a severe toxæmia from infected food. The clinical picture in either case is the same. The vaso-motor system is profoundly depressed, and the abundant flow appears to be caused by the relaxation of the



intestinal vessels supplied by the splanchnic nerves. The alimentary canal, as some one has said, presents a condition of millions of minute leaks, through which the young life rapidly drains away unless the leakage is soon stopped.

(c) *The Pasty-White or Musty Stool*.—This stool is often included by writers on the subject as a form of cholera infantum. The discharge is hardly visible on the napkin, and has the appearance of a paste made of water and chalk. The odor is musty or mousy, and is characteristic of this stool. There is usually a history of having taken indigestible food, or of its having been preceded by one of the other forms of diarrhœa. The general clinical symptoms are not as severe, usually, as in true cholera infantum, but are not markedly different from those of other diarrhœas. The stool indicates a complete atony of the glands of digestion. Through the influence of micro-organisms every gland in the alimentary canal appears to be inactive.

(d) In the next class of dyspeptic diarrhœa the stools may be divided into two varieties. The first of these is characterized by a discharge leaden in color, acid in reaction, and by the sour, disagreeable odor of fermentation. The second is characterized by a grass-green stool, alkaline in reaction, and of a most foul and offensive odor. Intermixed in the discharges of both the acid leaden and the alkaline green stools may be seen curds of undigested food. The first is typical of the bacteria of fermentation; the second of the bacteria of decomposition; and the alimentary canal affords a splendid test-tube for the cultivation of these organisms.

This disease is one of hot weather, the warmer temperature making the always easily infected milk still more congenial to the growth of the bacteria, which gets into it through unclean nursing-bottles, contaminated nipples, and in many other ways.—*N. Y. Medical Journal*, 1897.

ACUTE ASCENDING PARALYSIS OCCURRING IN THE COURSE OF ANTIRABIC TREATMENT.—Before the Paris Academy of Medicine Rendu related that in March last an attendant at the Necker Hospital, while performing an autopsy on a subject who had just died of rabies, pricked his finger while cutting the pancreas. A few days later he applied at the Pasteur Institute, and the regular antirabic treatment was pursued. He was suddenly taken on the 1st of April with spasmodic rigors and fever, which increased the next and following days, and there ensued progressive symptoms of the gravest character, such as paraplegia of the lower limbs at first, then of the upper, paralysis of the sphincters, vomiting, dyspnœa, tachycardia, etc., all with moderate temperature. Antirabic injections were nevertheless continued, together with antipyrine. On the seventh day a marked amelioration was observed, and in three weeks there was complete restoration. He did not think the case one of paralytic rabies, as the duration of incubation was too short; nor was the clinical course or termination what might in that case be expected. A more plausible hypothesis would be that of an acute ascending paralysis of toxic origin. He questioned whether the toxines were introduced by the antirabic injections, since the cure supervened in spite of the continuation of the Pasteur treatment, but inclined to think that the patient, who by the requirements of his occupation was eminently exposed to infection, was in a condition of morbid receptivity, and hence while under the influence of antirabic toxines there was the possibility of the invasion of myelitis.

In the course of the discussion Roux opposed the interpretation of M. Rendu, citing an analogous case reported by Laveran, and claiming that both were abortive forms of rabies. Grancher stated that since the inauguration of the Pasteur treatment numerous cases of so-called paralytic rabies have been observed, generally produced by hysteria or alcoholism. Brouardel stated that he did not deny that the emulsions of the medulla used in the treatment act by virtue of a certain toxin. 'As respects acute myelitis of infectious origin, it is far from being rare; a number of these cases have been described in France and elsewhere, many of which were verified by autopsy. Microbes of all kinds—streptococci, Eberth's bacilli, those of anthrax, etc.—have been found. It seems, then, legitimate to think that M. Rendu's patient was subjected to the influence of some malignant affection to which the anatomical puncture served as a medium of introduction. So far as he knew, the transmission of rabies from man to man has not been proved. There remains the question of paralytic rabies. Laveran cited one case from personal experience. But paralytic rabies was known long before the creation of the Pasteur Institute. Van Swilten spoke of it, and it is nearly certain that paralysis of this kind, so far from being a check upon the Pasteur method, owes it to the antirabic injections that they are not more frequent and more grave.—*N. Y. Medical Times*, 1897.

**A STATISTICAL STUDY IN EPILEPSY.**—Clark has carefully studied ninety-five hundred and forty-five epileptic seizures occurring in one hundred and fifty cases admitted to the Craig colony during the past year. The results show that contrary to the experience of some investigators no periodicity exists; and, moreover, in the case of the female epileptics, often in contradiction to the statements of friends, there was no constant relation between the seizures and the menstrual epochs. Although from the fact that epilepsy is a disease that often makes its first appearance during the night, and frequently remains nocturnal for years, we might infer that the greater number of attacks would occur at night, the records of the colony show that the day seizures exceed in the ratio of five to four. The latter fact may be accounted for by the fact that in a majority of cases the bromide-chloral treatment was used, and chloral given at night is capable of throwing nocturnal seizures into diurnal ones. The greatest number of attacks were found to occur at four o'clock in the morning, the least number at seven o'clock at night. The diet for epileptics has been so arranged that the heaviest meal of the day occurs at noon, stomachic digestion probably being completed two hours later; and it is interesting to note that there then ensues a remission in the frequency of attacks that continues until the nine o'clock hour. Another fact, possibly bearing upon the auto-intoxicant theory, is, that nearly one-half of the patients admitted to the colony suffer from constipation in more or less severe form. As for the greatest number of attacks occurring at 4 A.M., two reasons may be given: that it is one of the hours farthest away from the sedative doses, or that the vital forces are then at their lowest ebb, and the nervous system is especially defenceless and open to the reception of reflex action.—*Medical Record*, 1897.

**THE DIFFERENT FORMS OF CARDIAC ARHYTHMIA AND THEIR TREATMENT.**—According to M. Houchard (*La Med. Mod.*), we may, from a pathological and ætiological point of view, divide the arhythmias into six classes:

1. Neurotic or psychical (emotions, hysteria, neurasthenia, exophthalmic goitre, hypochondria).
2. Nervous and cerebral (meningitis, cerebral or meningeal hæmorrhage, cerebral tumors, compression of the pneumogastric, etc.).
3. Reflex (diseases of the stomach, of the intestines, of the uterus and its adnexa, and of the liver).
4. Toxic (digitalis, coffee, tea, alcohol, chloroform).
5. Critical arhythmias of acute diseases (in convalescence after typhoid fever, during the crisis in pneumonia, etc.).
6. The arhythmias of heart disease (mitral insufficiency, mitral stenosis, cardio-sclerosis, senility, acute myocarditis of the fevers, endocarditis and pericarditis, adherent pericardium and aortic regurgitation, and obstruction of arterial origin).

From a therapeutic point of view, the different classifications will not avail us much, and we will divide them into two classes: those in which the treatment must be aimed at the removal of the cause, and those which must be treated by digitalis and other cardiac tonics.

A.—1. In toxic arhythmia the removal of the cause is generally sufficient for a cure, except where, through long-continued use of the toxic agents (coffee, tea, tobacco, alcohol, etc.), gastric trouble has been produced. The treatment must, of course, then be directed to the latter also. We may mention here that in inveterate smokers a sudden cutting off of tobacco may produce an aggravation of all the cardiac symptoms, and it may therefore be necessary to diminish the quantity smoked daily slowly and gradually.

2. In arhythmias of reflex origin—gastro-intestinal, uterine, hepatic—the treatment must, of course, be directed to the original cause.

3. It is very important to keep in mind that even in organic diseases of the heart the arhythmia may be of gastric origin, may be due to hyperacidity or subacidity of the gastric juice; and while digitalis would be of no avail, an alkaline or even hydrochloric acid mixture—as the case may require—will relieve the symptom. When there is a nervous element associated, quinine hydrobromate, from 9 to 12 grains a day, potassium bromide and atropine, will be found useful.

4. There are arhythmias which may be aggravated by the immoderate use of digitalis, and the author has cited cases of rapid or sudden death from the employment of this drug in patients with arterio-sclerosis and a double cardiac rhythm.

5. In arhythmia of nervous or cerebral origin, digitalis will prove useless.

B.—The form of arhythmia where digitalis will do much good is the one in mitral insufficiency, especially when it is of mechanical origin. Where it is due to degenerative changes of the myocardium, digitalis frequently disappoints us, and strophanthus is then preferable to any other medicament.—*A. M. S. Bulletin.*

A UNIQUE CASE OF COMPLETE REMOVAL OF THE STOMACH.—Great interest has been excited by the report of the successful removal of the entire stomach by Dr. Carl Schlatter, of Zurich. According to his own record of the case, published in the *Medical Record* (Dec. 25, 1897), the patient, a woman of fifty-six, was admitted to the hospital suffering from the classical symptoms of cancer of the stomach. Operation afforded the only chance of relief, and ac-



cordingly laparotomy was performed. The entire stomach presented itself in the shape of a hard mass extending from the cardiac to the pyloric extremity, and, strangely enough, the entire mass was freely movable. The entire organ was excised, but it was found impossible to join the duodenal opening with the œsophageal by direct suture. Therefore he invaginated the duodenal rim and closed the opening by a double suture. He then secured a suitable knuckle of intestine from about fifteen inches further along the duodenal-jejunal fold, and this was sutured to the œsophageal stump. The patient made a comparatively quick recovery, interrupted only by several attacks of vomiting, and three months later is said to be in good health. Microscopical examination showed the tumor to be a small-celled alveolar glandular carcinoma.

Dr. E. C. Wendt, of New York, considers the following conclusions justifiable :

1. The human stomach is not a vital organ.
2. The digestive capacity of the human stomach has been considerably over-rated.
3. The fluids and solids constituting an ordinary mixed diet are capable of complete digestion and assimilation without the aid of the human stomach.
4. A gain in the weight of the body may take place in spite of the total absence of gastric activity.
5. Typical vomiting may occur without a stomach.
6. The general health of a person need not immediately deteriorate on account of removal of the stomach.
7. The most important office of the human stomach is to act as a reservoir for the reception, preliminary preparation and propulsion of food and fluids. It also fulfils a useful purpose in regulating the temperature of swallowed solids and liquids.
8. The chemical functions of the human stomach may be completely and satisfactorily performed by the other divisions of the alimentary canal.
9. Gastric juice is hostile to the development of many micro-organisms.
10. The free acid of normal gastric secretions has no power to arrest putrefactive changes in the intestinal tract. Its antiseptic and bactericide potency has been overestimated.

THE SURGICAL TREATMENT OF EPILEPSY, ITS INDICATIONS AND CONSEQUENCES.—To the International Congress of Neurology, of Psychiatry, Medical Electricity and Hypnology, held at Brussels, September 14-19, 1897, Winkler, of Amsterdam, reported the following conclusions :

1. Reflex and topical epilepsy may present unilateral or local spasms, the same with traumatic epilepsy and that due to any other lesion more or less circumscribed of the brain. It is not cortical epilepsy alone which begins with local or unilateral convulsions.
2. Every epilepsy is symptomatic, and a symptomatic epilepsy cannot be separated from a true or idiopathic epilepsy, and consequently epileptic surgery does not exist ; it is that of the brain and the cranium.
3. An epilepsy may necessitate surgical intervention only when the cerebral lesion permits the intervention ; that is to say, when the lesion can be located with certainty, is accessible and sufficiently circumscribed to permit of complete extirpation.
4. That which he denominated a diseased condition—*etat de mal*—with

unilateral spasms, preceded, accompanied or followed by monoplegia or hemiplegia of the convulsed side, always indicates temporary extensive osseous resection of the opposite motor zone.

5. Circumscribed tonico-clonic spasm that acts as an initial symptom and signal of unio-lateral or general convulsions, or that constitutes the entire attack, with or without loss of consciousness, indicates surgical interference in case of visible wound of the cranium, provided there is a topographical identity between the wound and the centre which is presumed to be the point of departure of the signal symptom.

6. In case of topographical difference between the exterior cicatrix and the presumed motor-centre, or when the exterior traumatism is defective, the aura preceding the motor-signal symptom acquires, if it exists, an extreme value.

7. The sensorial aura of an extremity, in which the signal-motor symptom begins, accompanied often by paralysis of muscular power, indicates a lesion of the parietal lobe, posterior to the motor zone.

8. The visual aura, often connected with the preceding, and preceding, too, the signal-motor symptom (in this case rotation of the eyes and of the head to the opposite side), and often accompanied with an incomplete hemianopsis of the inferior part of the visual field, presumes a lesion of the angular convolution of the cuneus.

9. The aura of memory—aura intellectualis—often connected with an epileptic or an olfactory aura, and preceding the motor-signal symptom, induces suspicion of a lesion of the frontal lobe, especially the right.

10. The results obtained by surgical intervention in epilepsy are satisfactory when a lesion is absolutely reachable and can be completely removed. The extirpation of a centre which presents no lesion to the naked eye is not permissible, except in cases where it can be demonstrated that the centre plays the rôle of a discharging lesion. At present the only means of making this demonstration consists in reproducing by faradic excitation of the centre an attack absolutely similar to the spontaneous attacks.—*Medical Times*, December, 1897.

F. MORTIMER LAWRENCE, M.D.

**SURGICAL HINTS.**—In the treatment of abscess, free drainage is far more important than the use of chemical antiseptics.

In ligating vessels the fine ligature is best so long as it is strong, for the knot is less liable to slip.

Cancer of the breast occurring during pregnancy or lactation is particularly malignant, and is of very rapid growth.

Do not drain a healing cavity for too long a time. Your drain may be acting as a seton, actually keeping up the suppuration.

A tumor which, having existed for a long time, suddenly begins to grow, should be regarded with the gravest suspicions. It is probably malignant.

In draining spaces whose walls are flaccid and tend to fall together, gauze does very well. When there is a true cavity, however, a tube will usually be more efficient.

In diagnosing abdominal tumors it is always best to clear the patient's bowels thoroughly, and then palpate in full surgical anæsthesia before venturing a positive opinion.

When chronic intestinal obstruction is caused by carcinoma, wherever lo-

cated, there is practically always an intermittent pain, of a paroxysmal nature, situated in the region of the umbilicus.

Dermoid cysts at the outer angle of the brow are often taken for lipomata or for wens. These dermoid cysts are not easy to remove, for they are very firmly attached to the bone, often, too, by a wide base.

If you are about to examine a septic case, or one where you suspect syphilis, wash your hands with vinegar or dilute acetic acid, and you will soon discover by the smarting any little scratches or abrasions in your skin which might become the starting-points of infection.

THE STERILIZATION OF CATGUT BY THE JEFFERSON METHOD.—Keen (Philadelphia) has used catgut prepared by heat, alcohol, cumol, etc., and has discarded these methods because of the costly apparatus and special care necessary in their employment. He describes a method, in the *Annals of Surgery*, which has the advantage that the needed materials are easily obtained, and the only other requisites are a few bottles or jars and a very few minutes' time. It is, therefore, peculiarly adapted to men in the country or small towns, where it is impossible to carry on more troublesome methods.

Three things are necessary to make the use of catgut desirable. First of all, that the catgut shall be absolutely sterile. Catgut prepared by the method about to be described has been repeatedly tested, and in no single instance have any growths occurred, even in stout catgut. The clinical test in hundreds of cases has been as satisfactory as the bacteriological.

Secondly, the gut must be strong. No. 1 catgut can be used when prepared by this method for the small vessels. It can be broken, of course, but only with considerably more force than would be necessary to ligate the small vessels. No. 2 will not break easily. No. 3 requires very considerable strength to break it, and above that size it is very difficult with the utmost strength to break the catgut. The thicker sizes are, therefore, suitable for ligation of stout pedicles. Anyone who has had experience with the annoyance, especially, of stout silk and the sinuses caused by it, will be very glad to know that the catgut is not only aseptic, but is strong and readily absorbed. If it is desired to have the gut more slowly absorbed, it can be chromicized to any desired degree.

Third, the catgut must be flexible enough to tie in a reliable knot. This catgut has been found to answer that purpose as well. Steep the gut, as received from the manufacturer, in the best ether. Allow light gut to remain in it for not less than 24 hours; heavy gut for 48 hours. When it has been steeped a sufficient length of time in the ether, transfer it directly into a mercuric-chloride mixture consisting (proportionally) of 40 grains of mercuric chloride and 200 grains of tartaric acid in 12 fluid-ounces of 95 per cent. alcohol. Very fine gut should not remain in the mercuric mixture longer than from 5 to 7 minutes, the next size 10 to 15 minutes, and the third and fourth sizes from 20 to 25 minutes respectively. Before transferring the gut from the ether into the mercuric-chloride mixture, jars for keeping it ready for use should be at hand, thoroughly scalded, and then bathed in an aqueous solution of mercuric chloride (1-1000). When the jars are ready they should be nearly filled with alcohol (95 per cent.) containing palladium-bichloride in the proportion of one-sixteenth of a grain (two drops of a solution which contains 15 grains of the salt to the ounce) to the pint of alcohol (more of



the true bichloride of palladium will not stay in solution in alcohol, and when a precipitate occurs, through excess of the palladium, the whole goes to the bottom, and is not soluble in alcohol). As the gut is lifted from the bichloride mixture it should be dropped into the prepared alcohol, and is then ready for use, and will keep, as far as is yet known, for any length of time. The quantity of gut judged necessary for the operation should then be lifted out by means of a sterilized instrument, and dropped into a dish previously sterilized for the purpose, and having sufficient alcohol in it to keep the gut from drying. If any of the quantity laid out for use at an operation is left, it may be put back again into the jar, but should first be immersed in the corrosive mixture and left for two or three minutes in it. H. L. NORTHPROP, M.D.

EXPERIMENTAL CONTRIBUTION ON THE ACTION OF HYDRASTIS CANADENSIS AND OF ERGOTIN UPON THE UTERUS.—(Fellner.)

As a result of careful experiments Fellner has arrived at the following conclusions :

1. Hydrastis canadensis as well as ergotin produces marked uterine contraction after its intravenous or subcutaneous injection.

2. The effect is direct ; that is, it is not caused indirectly by its influence upon the vessels.

3. Contractions after ergotin are more powerful than those after hydrastis, and follow each other more rapidly ; they are of longer duration and of tetanic character, while the contractions caused by hydrastis are always separated by periods of relaxation, especially after repeated doses.

4. Both drugs after repeated use of large doses, and especially after intravenous use, lead to a paretic condition of the uterine muscle—more rapidly with hydrastis than with ergotin.

5. Both preparations increase the blood pressure and the heart's action, and the uterine contraction may occur with either a diminution or an increase of blood pressure.—*Wiener Med. Presse*, 1897, No. 15 u. 16.

CONTRIBUTION TO THE STUDY OF SECONDARY LAPAROTOMY.—(Noltschini.) Any laparotomy may have, for its sequelæ ileus, internal hæmorrhage, closure of the ureter, or general peritonitis. In these cases secondary laparotomy is the only remedy for removing the threatening danger. The question of adhesions causing ileus has been repeatedly discussed and experimentally investigated. In a Moscow gynæcological clinic from 1890 to 1896 there were fifteen secondary operations after 654 laparotomies ; in 10 of these cases ileus was the indication for operation.

A differential diagnosis between intestinal paralysis, ileus and peritonitis is very difficult. Feculent vomiting, upon which many authors lay stress, is a symptom which usually comes too late for the operation. Others attach particular importance to meteorism distending the pit of the stomach while the epigastrium is retracted.

Hirsch emphasizes the presence of indican as an important sign. In Moscow the abdomen was irrigated with salt solution after the operation and a strip of iodoform gauze was introduced. Only one case of ileus was seen after an operation for cysts. In the Moscow clinic the stump was covered with peritoneum, which he believes accounts for the rare occurrence of ileus. In 33 per cent. of the cases of ileus the operation stump showed adhesions with the intestines. In other cases there was mechanical closure of the

intestine, an adhesion with the omentum, or intussusception. The introduction of asepsis instead of antiseptics has not diminished the number of cases of ileus.

The time at which the first symptoms of closure of the intestine appeared had no influence on the success of the operation; neither the time which had elapsed from the first symptoms of ileus to surgical interference. The result of the operation depended entirely upon the strength of the patient. Weakness, collapse and intestinal paralysis must therefore be considered as contraindications to undertaking the operation. Under all other circumstances secondary laparotomy is indicated in ileus, as the mortality of this operation is then only 38.5 per cent.

In internal hæmorrhage and the ligation of the ureter, the opening of the abdominal cavity is indicated; but special indications for operative interference in general peritonitis cannot be given. There are two points of importance in prophylaxis—1st, we should give heed to the observations of Fritsch that too frequent use of laxatives before the operation should be avoided, as this weakens the intestinal muscle; and, 2d, the peritoneum should be carefully protected during the operation from any mechanical or chemical irritation.—Transactions of the International Congress at Moscow, *Centralblatt für Gynäkologie*, No. 39.

GEORGE R. SOUTHWICK, M.D.

**THE EYE IN TYPHOID FEVER.**—Dr. Charles Steadman Bull, of New York, calls attention to the fact that various lesions of the eye may occur in typhoid fever, not only during the height of the disease but also during the period of convalescence. These lesions in the order of their frequency may be enumerated as follows: *Conjunctivitis*, which is characterized by no marked objective symptoms; the patient complains of the lids feeling rough and hot.

*Phlyctenular Conjunctivitis* and *Keratitis*.—There is a development of clear transparent vesicles usually along the corneal margin. These phlyctenular affections are apt to be seen in the period of convalescence.

*Loss of Accommodation and Paralysis of the Sphincter Muscle* (causing dilatation of the pupil).—Both of these conditions may occur at the height of the disease as well as during convalescence, and are due to the general asthenic condition rather than to any lesion of the iris or of the ciliary body.

*Retinal Hemorrhages*.—Most commonly occurring in the height of the disease, and they may be so extensive as to break through into the vitreous body. These cases are the ones which are usually accompanied with intestinal hæmorrhages.

*Paralysis of External Muscles* occurs during convalescence, and sometimes long after; the prognosis in such cases is very good.

*Retinitis or Retrobulbar Neuritis*.—This complication is supposed to be due to a more or less circumscribed meningitis at the base of the brain. Atrophy of the nerve is the result.

*Inflammation of the Uveal Tract*.—Iritis, cyclitis and choroiditis, both plastic and serous, are occasionally seen in the height of typhoid fever. Vision as a rule is permanently impaired, especially when either the choroid or the ciliary body is involved.—*Medical Record*.

**DISAPPEARANCE OF PTOSIS AFTER CORRECTION OF ASTIGMATISM.**—A female patient, aged seventeen, had a marked ptosis of the left eye, the right being affected to a much slighter extent. This condition had existed for some

years. Examination revealed a hyperopic astigmatism of the right eye and a myopic astigmatism of the left. Six months later, the ptosis was found to have almost entirely disappeared while wearing the glasses, but recurs at once in a marked degree when they are removed, the change being quite involuntary. F. W. Marlow—*Annals of Ophthalmology*.

**OCULAR HEADACHES.**—If every general physician could read Dr. Greenwood's article upon "Ocular Headaches" and profit by its lessons, there would be much less suffering than there is in the world. His experience corresponds accurately with that of every careful oculist.

He reports a table of 900 cases of error of refraction and muscular insufficiencies; 480 of these cases suffered with headache, while the other 420 were without headache, yet suffered from other asthenopic symptoms. The larger proportion, 30 per cent., were entirely relieved, 15 per cent. were partially relieved, 5 per cent. were unrelieved, and in 7 per cent. the result was unknown.—*The Boston Medical and Surgical Journal*.

**CHRONIC ANÆMIA OF THE LABYRINTH AND THE AMYL NITRITE TEST.**—Lermoyez recommends the amyl nitrite test for differentiating between labyrinthine congestion and anæmia in cases of deafness, and cites a case in which the inhalation of the drug nearly doubled the hearing, the tinnitus present also disappearing.

All that is necessary is to make the patient inhale 5 or 6 drops of this substance and compare the auditory acuity before and immediately after this inhalation. If the deafness and tinnitus are due to congestion of the labyrinth, they increase in a marked degree; but if, on the contrary, they are dependent upon anæmia of the inner ear, there is an immediate improvement, hearing being markedly sharpened, as after an air douche.—*French Soc. Otolology and Laryngology*.

**OTITIS MEDIA ACUTA HÆMORRHAGICA.**—Mr. Nash records a case of otitis media acuta hæmorrhagica of both ears, causing rupture of both tympana, involving the mastoid cells, and ending in complete recovery. The hearing power, when resolution set in, was perfectly normal. The early and free hæmorrhage that occurred was undoubtedly of benefit.—*The Lancet*, Dec. 18, 1897.

**HYPERTROPHY OF THE LINGUAL TONSIL.**—Bowen discusses hypertrophy of the lingual tonsil in its clinical aspects. The condition, while not very common, is also not rare. Hypertrophy of the lingual tonsil, in contradistinction from that of the faucial tonsil, is a disease of adult life. The etiologic factors are numerous; some definite, others obscure. Pathologically the cells undergo regenerative changes peculiar to all neoplasms. Uncomplicated, the disease is a purely local one and unattended with premonitory symptoms. The growth varies in size in different patients, those with the largest growths not always suffering the greatest distress. The diagnosis can be made only with the aid of a laryngeal mirror. The methods of treatment are variable, though all have the same object in view, namely, the destruction of the growth. The knife should, however never be used, on account of the large number of bloodvessels at the base of the tongue. The use of the galvano-cautery is the ideal method of treatment.—*The New York Medical Journal*, December 25, 1897.

WILLIAM SPENCER, M.D.



## MONTHLY RETROSPECT

### OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

---

**A STUDY OF KOLA AND CRATÆGUS AND STROPHANTHUS.**—Duncan, of Chicago, insists that a remedy intended to cure according to the law of similars must be selected in accordance with its secondary, not primary, symptoms. In a proving of a reliable preparation of kola by students it was found that the drug stimulated at first, but that was followed by depression and great muscular soreness. For that the general practitioner can use it according to similia.

Cratægus sends up the pulse and quickens the heart, but the reaction, the secondary effect, is to produce a weak heart with slow, full pulse—the range of digitalis, neither so high nor so low. The mental effect is also more soothing. So it is homœopathic and curative for its secondary symptoms, and must be given in small doses.

Strophanthus acts upon the heart in an entirely different fashion. It produces primarily a shock, a slow pulse, and intermittent heart-beat. Then follows a reaction. The pulse runs high and the heart is quickened. It is this kind of a heart that craves stimulants, so that the brain may get the necessary flow. The pathology is that of cardiac dilation. It has been found that seven drops of the tincture of strophanthus would relieve the heart of an old toper and thereby relieve the desire for stimulants. The small dose that will manifest only the secondary effects is the one to give if we desire to follow the guide of similia. Strophanthus is, therefore, “useful in weak, hypertrophied, irritable hearts, with tense arteries and a free discharge of urine.”—*Medical Century*, 1897.

**CARBOLIC ACID IN ECZEMA.**—Dearborn, of New York, states that this acid is not only an irritant poison to the tissues, but seems to deprive the protoplasmic elements of the power of regeneration of tissue in the affected part. It exerts a paralyzing influence on the nerve-centres, permitting a prolonged dilatation of the bloodvessels, especially of the head and face. Hence, the type of cutaneous disease to which it is adopted is attended with great redness, a marked tendency to persist, to extend or to destroy tissue, even when under treatment. The sensations produced in the cutaneous sphere are smarting, burning (heat), itching, biting, pricking or crawling, and if the congestion becomes passive in nature, there may be sensations of coldness (or cool to touch—rosacea) and rarely of horripilation. Prostration may be a general symptom. Aggravations occur at night, from touch and rubbing. Scratching gives some relief, especially if the lesions bleed, as they are apt to do if excoriated.

Eczema of the face, neck or scalp; papular, papulo-vesicular or papulopustular, but always presenting a marked redness of the surface which extends beyond the other lesions, if attended with fulness in the head, headache,

or constriction of the forehead and temples (indicating fulness of the blood-vessels), may be greatly benefited by the action of this drug. Eczema of the dorsal surface of the hands, fingers and between the fingers, with some of the lesions above mentioned, sensations and modalities like those of carbolic acid, quickly respond to the curative action of this remedy. In such cases the redness may be bright, in others dark, as the vascular dilatation is arterial or venous.

Carbolic should probably never be administered for its influence on the skin in a higher attenuation than the sixth decimal, and oftener the second decimal will be required.—*The Chironian*, December 15, 1897.

REMEDIES FOR GONORRHEA.—McCurtain, of Denver, suggests the following:

1. Aconite low for acute stage.
2. Belladonna if prepuce is swollen, red and shining.
3. Apis when there is the characteristic puffiness of the prepuce.
4. Gelsemium when the discharge has been suddenly stopped and orchitis is developing.
5. Argentum nitricum in purulent inflammations with a sensation as if the urethra were drawn up in knots.
6. Merc. corr. when the orifice is inflamed and there is a greenish discharge, often painless, especially at night.
7. Sulphur when other remedies apparently well selected fail to give results.
8. Carbo veg. may be useful when there are violent burning pains in the urethra and extremely offensive discharge.
9. Cantharis when cystitis. Farrington says it is indicated oftener than all other remedies in cystitis; particular indication, straining after urination.
10. Mygale lasidora for chordee.
11. Arching at the orifice with shuddering, nux vomica.
12. Contraction of the passage, bryonia, pulsatilla, sulphur.
13. Itching in the forepart of the urethra, ignatia, arnica, merc. sol.
14. Stinging when not urinating, acid phos.
15. Stitches, violent, extending its whole length, conium.
16. For soreness of the orifice, copaiba.
17. Discharge semen-like with burning pain, pulsatilla.
18. Discharge of whitish or yellowish pus, hepar sulph. calc.
19. Discharge yellow and thick, capsicum.—*The Critique*, December 15, 1897.

POTASSIUM IODIDE IN SPASTIC ATAXIC PARAPLEGIA.—Halbert, of Chicago, records the case of a man, aged 36, who came to his clinic with a diagnosis, given by a local doctor, of "neuralgia of the nerves." He suffered with pain and inability to properly use his limbs, his gait was decidedly spastic, and at the same time he had lost all power of co-ordination. Six months previously he began to notice that it was difficult to get up from a chair, and to descend stairs was almost impossible. He had lost absolute control of the sphincters, and there was no ability to regulate the fecal or urinary discharge. He complained also of fulgurating pains and heaviness and numbness of the limbs. His history gave no clue as to the cause of his condition, his habits were exemplary, and there were no signs of a specific taint.

Careful examination showed that his right leg had lost entirely pain sensa-

tion and electrical reaction, deep reflexes were lessened but not lost, muscle-sense was imperfect, and there was no co-ordinate control. The left leg presented almost contrary symptoms; the pain and touch sensations were exaggerated, electrical reactions increased, reflexes all exaggerated, and muscle-sense intact. In walking this limb flopped about with a decided spastic jerk. Neither limb showed any signs of wasting; the sign of Romberg was pronounced, but there was no involvement of upper or cranial nerves. The debility was apparently developing rapidly towards a paresis of the lower cord, the pathology including descending degeneration of the pyramidal tract and ascending degeneration of parts of Goll's and Burdach's columns. Hence his condition was a combination of spastic paralysis and ataxia, and as it involved only the lumbar cord it resulted in this peculiar paraplegia. He was given potassium iodide 3x and the regular application of static electricity. It is now four months since he began this treatment, and he is not only walking without the aid of canes but he has quite perfect control of his limbs. The sphincter debility has disappeared, he has gained flesh and strength, the sensations are more nearly normal, and he has returned to his work with every hope of eventful recovery.

In such a case the fibrinous exudate in the central cord structure was not sufficient to destroy the tract fibres, and hence the cure was possible. Had he, however, been given the lower potency of the remedy, the author fully believes that the degeneration would have extended to the deeper cord structure. This experience he has verified in many similar cases.—*Medical Visitor*, January, 1898.

**SOME REMEDIES IN PNEUMONIA.**—Brown, of Shippensburg, Pa., in reviewing the treatment of pneumonia pursued by him during the last winter, asserts that several cases which would undoubtedly have terminated in severe form, because of their rapid onset, were completely aborted in forty-eight hours with drop-doses of the tincture of iodine, repeated every one or two hours. The indications that lead to its use are severe chill, short and dry cough, rapid rise of temperature, developing hoarseness, great tightness of chest, early expectoration of blood, and tearing, stabbing pains in sides. As the cases progress, if they complain of great dryness in the throat, have red cheek on the affected side, cough with tough, rust-colored sputum, stitches and burning pain in chest, cannot lie with the head low, both sputum and breath smell bad, worse in afternoon, with hectic condition, *sanguinaria* 1x is his sheet-anchor. Indeed, this remedy and phosphorus are the principal ones for the later stages. *Phosphorus* is given when the pain is not necessarily so severe, but there is great weight and oppression of the chest, with difficult bloody mucous or purulent expectoration. There may be collateral œdema. The cough is tight, worse from talking, from a draught of air, and in the early evening. Expectoration is difficult, and there is severe dyspnoea with hoarseness, great debility and emaciation. If the drug is insufficient to relieve these symptoms; if the expectoration should become more purulent; and if with this there should be kidney complications, with heavy dragging in the renal region, suppression of urine, albuminuria, urine scanty, dark, and this brownish-red, with anasarca and weak rapid pulse, *ferrum arsenicosum* will cure the patient.—*Medical Century*, December 1, 1897.

F. MORTIMER LAWRENCE, M.D.



ON THE VALUE OF LACHESIS IN GANGRENOUS AFFECTIONS.—Dr. Lambrechts, fils, of Antwerp, Belgium, calls attention to the marvellous efficacy of naja, crotalus and lachesis in those infectious states of the blood which sometimes pass on to gangrene. In the pathogenesis of lachesis the symptoms of infection and decomposition of the blood dominate the scene. Under its influence all inflammations assume a remarkably malignant character.

Last April he treated a young man of twenty-eight years who, strong and robust, developed a particularly grave form of typhoid fever. Although various homœopathic remedies were prescribed he continued to become worse and worse. On the fourteenth day intestinal hæmorrhage set in, to be followed by profuse hæmaturia, which under ham. and acid. phos. decreased somewhat, when suddenly his penis swelled and became œdematous, and a blackish, shining spot appeared on the dorsum, which extended rapidly towards the glans, accompanied by the horrible odor characteristic of gangrene. The mortified parts were detached, thus exposing the glans and a part of the corpus cavernosa, which were covered with small and grayish ulcerations of a bad appearance. Antiseptic dressings of iodoform, after irrigation with a solution of carbolic acid, were applied. Eschars forming on the sacrum were also thus dressed. Under the influence of lachesis the gangrenous process was arrested. The patient, who was in a desperate state, with scarcely the breath of life left in him, improved considerably; the sacral ulceration cleansed itself and healed rapidly; the penile ulcer took on a healthier color and healed in fifteen days; his tongue cleaned up, his strength returned progressively with his appetite, and to-day he is in perfect health, and, beyond a circumcision, he presents no sign of the terrible danger which he ran.

While dressing this same case the writer accidentally inoculated a slight wound of his left index finger with the ichor from the penis. Though he immediately washed it antiseptically, the next day there were lancinating pains in the finger which progressively extended to the hand, forearm, and became so aggravated that he could not sleep the following night. The wound swelled and was bluish, livid, and of bad appearance. Under lachesis 6x the pains decreased considerably and abundant suppuration set in, the swelling decreased, and in ten days it healed completely, leaving a linear cicatrix which is now visible.

In a case of gangrenous erysipelas which, beginning in a woman of thirty-two years who was feeble and overworked, as a tonsillar erysipelas, after yielding rapidly in the throat to aconite and apis, it was followed by the disease invading the hands and arms. The affected surface was here and there covered with enormous bullæ, which, on rupturing, left large open ulcers, which exhaled a gangrenous odor. The patient's tongue became dry, and she was delirious at night. Lach. 6x with an iodoform dressing locally produced a favorable change in her desperate condition. The delirium ceased, her tongue moistened, and the fever decreased much in intensity. Convalescence was very slow on account of ulceration of the bullous surfaces. Unfortunately an abortion then also complicated at the third month of gestation. China and ars. restored her in six weeks to fair health.

In a case of gangrenous stomatitis in a child, a boy of seven years, who after measles was affected with a large, grayish-black ulceration of the bucco-gingival fold, which was associated with a strong odor of gangrene, with considerable œdematous swelling of the cheek and enlargement of the cervical and sub-

maxillary glands, a boric acid solution was applied locally and lach. 6x, a dose each hour. After four days of this treatment the gangrene had become limited, the ulceration had taken on a rosy aspect, and the swelling of the face had greatly diminished. In fifteen days cicatrization was complete. Calc. carb. caused the glandular swelling to decrease insensibly.—*Revue Homœopathique*, No. 10, 1897.

GLONOINE IN CEREBRAL CONGESTION.—Dr. Oscar Hansen, of Copenhagen, was consulted by a workman of thirty-five years, who for a number of years had been under allopathic treatment, without improvement. He complained of great "rushes" of blood to and heaviness in his head. On moving it, it would feel as if it would break. Throbbing, which was worse in the head, especially in the temples, forehead and vertex. Vertigo. While these seizures are present his face is dark red. Wine and being in the sun during the summer aggravate. Better in the open air otherwise. Heart normal; no history of any genital diseases. His appetite and functions all in order. He is a robust and strong man. Glon. 3x, three drops three times a day, in a teaspoonful of water. After a few doses his attack never returned, and he has remained well since.—*Maanedskrift for Homœopathi*, No. 11, 1897.

RHUS TOXICODENDRON IN SCARLATINA.—Dr. Nimier, in a study of rhus tox., recommends this remedy in scarlet fever when there are prostration, delirium, swelling of the throat, especially on the left side, with reddish discoloration of the skin in that region, red and smooth tongue, and somnolence. If the disease be complicated with parotiditis, then the drug is still more indicated. To differentiate it from apis, which has the same symptoms with rhus, the eruption is much more intense and darker red, and there is actual excitement of body, and not continual restlessness, as with apis. In the associated parotiditis it frequently precedes lachesis, chiefly when the inflammation is not pronounced, in the beginning and before the purple redness appears. It is also indicated when the scarlatinous eruption makes its appearance with difficulty.—*Zeitschrift des Berliner Vereines Homœopathischer Aerzte*, xvi., Bd. Hft. vi.

VERATRUM VIRIDE IN PYO-SEPTICÆMIA.—Dr. Francois Cartier, of Paris, recommends veratrum viride in *infections with great oscillations of temperature*, as in pyo-septicæmia, manifesting itself in the many different ways which it has been demonstrated, especially in later years by the German and French writers, as puerperal fever, cellulitis, erysipelatous phlegmons, pelvic suppurative processes, etc. These oscillations of temperature indicate most frequently an acute septicæmia, and are most always dependent on the streptococcus. He employed the tincture, in doses of four to six drops a day. It is wholly different from aconite in its action. The snake-poisons, tarantula cubensis, hepar, mercurius and mynistica are its analogues, but none of them have the characteristic "jumps" in the temperature. Surgical intervention is, of course, indicated and supplants this drug in pus formation, but where the purulent focus is of an unknown location or generalized this drug will take its place. Also in such a condition of internal organ it would be useful.—*L'Art Medical*, No. 11, 1897.

FRANK H. PRITCHARD, M.D.

# THE HAHNEMANNIAN MONTHLY.

---

MARCH, 1898.

---

## TACHYCARDIA AND EXOPHTHALMOS IN CHILDREN.

BY E. M. HALE, M.D., CHICAGO.

WHILE having under treatment several cases of chorea in children under 12 years of age, I found, on examination of the heart, that the pulse-rate was far too rapid.

The average normal pulse of a child at 3 years of age is about 120; at 6 years 100; at 12 years 90. The pulse of children under 12 is very apt to be irregular. This fact is not sufficiently taught in works on diseases of children. It may vitiate our diagnosis if we do not bear it in mind. Any slight derangement of the digestive system, worms, teething, fright, dentition, meningitis and anæmia may cause irregularity of the heart beats.

The pulse in children under 3 months is much slower during sleep, the difference being as much as 20 beats. These facts should be considered when treating chorea in children, which is supposed to be caused, in a large number of cases, by cardiac lesions. In the cases of chorea alluded to in the beginning of this paper, I found the pulse-rate in several cases much above the average normal, at the same time I could not discover any abnormal sounds indicating the slightest valvular lesion. In two of the cases the pulse was persistently irregular.



It then occurred to me that the chorea might be a concomitant of an *essential* tachycardia.

Although Mabijs asserts that chorea is a mere accidental complication of tachycardia in children, Kahler mentions a "Choreiform tremor" as common. I am certain choreic movements are frequently connected with tachycardia.

This leads to the question whether there occurs a real exophthalmus in early childhood? I have never seen but one case of tachycardia in children when there was any swelling of the thyroid. Perhaps, if I had examined each case more closely, I would have found it, and I am sure I never saw a case with protusion of the eyeballs. Grave's disease (exophthalmus, essential tachycardia) has rarely been mentioned in works on diseases of children. Keating makes but brief mention of it.

The following, from an editorial in *Pediatrics*, gives an excellent resume of our present knowledge of this subject:

"The disease has been more studied of late by Baldwin, Ehrlich and Kronthal. Steiner, of Vienna, has summed up our present knowledge in three important papers, in which he gives forty-four cases, including three of his own. He remarks that, while one hysterical patient in eight is a child, a doctor is fortunate who sees exophthalmic goitre in a child once in fifty cases; the sexual proportion is rather more than two to one in favor of the female. The symptoms usually come on successively and simultaneously; about a sixth of the cases are imperfect. In 40 per cent. of cases the heart symptoms are the first to appear, in 35 per cent. the exophthalmos, in 25 per cent. goitre, and in 10 per cent. tremor; sometimes, as the figures show, two symptoms appear simultaneously, or the disease may begin with secondary rather than cardinal symptoms. The disease reaches its height in children distinctly sooner than in adults.

Of the heart symptoms, tachycardia is the most important and constant. Curiously enough, it is less marked in degree than in adults, the pulse-rate seldom exceeding 100-120 per minute.

Palpitation is also less complained of, although cardiac dilatation is present in half the cases. A third of the child-patients develop a mitral systolic murmur as against two-thirds of adults. Enlargement of the thyroid is constant in children, though

absent in 15 per cent. of adults; in the former it is seldom very great. In about one-half the cases it affects both lobes equally; in the remainder the right is usually more enlarged. In 16 per cent. of cases there is pulsation of the thyroid; in 10 per cent. a murmur can be heard in it. The development of the goitre is much more rapid than in adults, the thyroid often reaching its maximum size within four to six weeks.

The exophthalmos is the least constant symptom of the triad, as, in adults, it is absent in one-fifth to one-sixth of the cases. It is, as a rule, less marked than in adults, and is often imperfect or difficult to detect. It is almost exclusively bilateral, and usually more marked on the left side than on the right, thereby contrasting with the goitre. It is particularly noteworthy that Von Graef's and Stellwag's signs are rarely present in children, the former being found only in 6 per cent., and the latter in 10 per cent. Steiner states that, although no doubt due to a common cause, they have never been observed together in a child. Actual ocular affections, such as ophthalmophlegia, superlachrymation, limitation of the field of vision, and keratitis, are in children rare concomitants, while Steiner asserts that nystagmus is absent.

Tremors are more common in children, and particularly in girls, than in adults; they are of two kinds: the fine vibrating movement described by Charcot and Maire, and the choreiform tremor by Kahler. The latter is an affection of co-ordination, and differs only from true chorea in being less extensive. The former tremor is present in one-eighth of all cases in children, the latter in one-fifth. Chorea itself is said by Mobius to be a mere accidental complication. Of secondary symptoms digestive changes occur in about one-half of all cases of the disease, but only in one-third of children affected by it. Diarrhœa is by far the most common: in 13 per cent. there is vomiting resembling that of hysterical origin. Anorexia, which is a symptom practically never found in adults, is present in 10 per cent. of children.

Dyspnœa is the commonest of respiratory symptoms, but is less frequent than is usual in goitrous cases, being present only in 29 per cent. Nasal disease, to which exophthalmic goitre is often attributed, is never associated with it in children.

Nervous symptoms are numerous and variable; hysterical

stigmata are evident in more than half the cases, and are by Möbius held accountable for the majority of the nervous manifestations. Motor disturbances are rare, with the exception of tremor and chorea, and the reflexes are as a rule natural. Sensory affections are still more uncommon, headache being present in only 13 per cent. and giddiness in 10 per cent.

Anæsthesia and paresthesia are practically unknown, but insomnia, probably of hysterical origin, is present in 25 per cent. of cases.

Of the psychical changes, that indisposition is the most marked. The patient becomes restless and irritable, bad-tempered and untruthful; speech is hurried, and the child flies from one pursuit to another without persisting long in any. More severe psychoses are rare. Skin symptoms are fairly common; the epidermis is thin, and blushing is readily produced, the ears being particularly affected. Abnormal hydrosis is recorded in 10 per cent. of puerile cases, but abnormal pigmentation is excessively rare. The temperature is raised in 13 per cent. of cases, but this is usually due to some complication. Wasting is common, occurring in 25 per cent. of cases and running a parallel course to that of the other symptoms, with the improvement in which it as a rule abates.

To sum up, the points in which the exophthalmic goitre of children differ from that of adults are as follows: The development of the disease proceeds more rapidly, the tachycardia is much less marked, the subjective sensation of palpitation is less conspicuous, the thyroid affection is constantly present, while the exophthalmic signs are confined to a relatively small proportion of cases.

Sexual disturbances are absent, but a combination with chorea is relatively frequent.

This last observation leads to the question of the relation of true exophthalmos to the sexual functions.

The fact that goitre predominates in women—that from 80 to 90 per cent. occurred in females, would seem to support the theory of a possible sexual origin. But if exophthalmus occurs in children before puberty, what becomes of the theory? There may be two kinds of Grave's disease, one essentially a neurosis, the other due to some sexual influence not yet understood; one due to an excitation of the inhibitory nerves governing the



heart, the other to an abnormal condition of the thyroid. As not all cases of goitre are attended by a rapid action of the heart, so some of the worst cases of tachycardia exist without swelling of the thyroid or protrusion of the eyeballs.

The *treatment* of essential tachycardia differs from the treatment of typical exophthalmus. The former may be controlled by veratrum vir., strophanthus, digitalis, lycopus or aconite, which have no permanent effect in typical exophthalmus, which requires fucus, baryta iodide, lapis alba, thyroïdin (in myxœdema) and spigelia when there is protrusion of the eyeballs.

To be successful these medicines must be used in the proper strength, and at appropriate intervals. I have found by experience that the dose of fucus should be 5 to 10 drops after meals; baryta iodide, a grain of the 2x after meals; lapis alba 6x trituration, 1 grain half an hour before meals and at night; thyroïdin, or the extract, 5 to 10 grains three times a day, and spigelia, 6th dilution, a drop four times a day.

The remedies for essential tachycardia I have found most useful in the 1x or 2x dilution. I am of course designating the dose for children under twelve years of age.

NOTE.—The preparations from the thyroid should not be used in material doses when the gland is swollen and at the same time its functional activity is increased.

Crude doses are injurious in such a condition, but if the function of the gland is arrested by extirpation, induration or atrophy, then the crude gland acts as a physiological remedy, taking the place of the absent secretion.

Large doses of thyroïdin cause some symptoms similar to exophthalmus and tachycardia, and it is probable that the attenuations may be of value in removing such symptoms.

---

THROAT LESIONS IN ENTERIC FEVER.—In a series of four cases Dr. Tresileau calls attention to a peculiar circular ulcer, with a stippled appearance, occurring in the fauces during the first week of the disease. Acute pharyngitis is also present.

This specific ulceration may occur at a period before the diagnosis of typhoid fever can be easily made from other symptoms. In such cases the possibility of contagion by breath might occur. The throat lesions heal rapidly under an antiseptic spray. Laryngeal stenosis, occasionally resulting from perichondrites, in this disease have been reported.—*Jour. of L. R. et O.*

## THE TREATMENT OF ABORTION.

BY C. R. NORTON, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

IN presenting this subject, which I want to make as practical as possible, I shall include the treatment of abortion only as it occurs in the first four months of pregnancy. The subject may, for convenience, be divided into the prophylaxis of threatening abortion, the treatment of the abortion itself and of the incomplete type, and the management of the cases afterward.

Under prophylaxis we must consider whatever may affect the general health of the patient, the treatment of constitutional diseases, particularly syphilis, responsible for such a large number of abortions. We must see that the various local disorders of the uterus and its appendages are remedied, particularly displacements, and especially backward displacements, the more so if there are adhesions. We must advise regarding diet, exercise, and, in fact, the whole conduct of living—particularly to those who are prone to miscarry. Since abortions are more likely to occur at the time when the normal period would have taken place, it is often wise for the pregnant woman to remain in bed for the few days of such time for several months in early pregnancy. The action of the bowels should be regulated and the function of the kidneys closely watched—in short, the entire life of the woman should be so regulated as to make it as healthful as possible.

When abortion threatens, and we find in a pregnant woman bleeding and pain, and upon examination an undilated os and cervical canal, we should put such a patient in bed, maintain absolute recumbency, see that the bowels are moved daily, that the diet be light and non-stimulating, and give a remedy according to the indications, the most frequently required being the class represented by *viburnum-crotophyllum*, *sabina* and *ergot*. It may be necessary to obtain the quieting effects of opium in physiological doses. No tampon should be applied unless, on account of excessive hæmorrhage, we are willing to assume the risk of converting a threatened abortion into an

actual one—the tampon having the property of stimulating the pregnant uterus to contraction.

The patient should remain in bed for a few days, until the threatening symptoms have passed away.

If, however, the bleeding and pain continue, if the cervical canal is open, if there is fever, offensiveness of the lochia, and particularly if we have a history of an instrumentally produced abortion, we should not prolong the tentative measures. Except in the presence of marked septic symptoms, or in cases, above mentioned, of induced abortion, we may refrain from the more active measure of instrumental interference, and, instead, proceed to tampon the vagina. In doing this the most careful antiseptic precautions should be observed. The patient should be prepared as for an operation—the external genitals thoroughly cleansed, the vagina well mopped with absorbent cotton, held by dressing forceps, and wet with an antiseptic solution of creoline, lysol or carbolic acid.

The bladder should be emptied. The doctor should take all the pains to be clean that he would if preparing for a major operation—hands and forearms scrubbed and soaked in an antiseptic solution, and the instruments made sterile. For the tampon I have used absorbent cotton wet with a 1 per cent. creoline solution, squeezed as dry as possible, and torn into flat pledgets perhaps an inch and a half in diameter.

With the patient in the Sims position, and with a Sims speculum in the vagina, I first cover the cervix with a few thicknesses of iodoform gauze, and then insert the pieces of cotton around and over the cervix and make a firm tampon to nearly fill the vagina—finally applying a sterilized napkin snugly to the vulva to complete the operation. This tampon may remain for twelve hours, and upon its removal the ovum is frequently found to be in the vagina or lying in the cervix, so that it can readily be taken away. Should this not be the case, the tampon may be applied two or three times, with, however, due regard to the appearance of any sepsis.

Should this measure not prove completely successful, it will be necessary to mechanically remove the contents of the uterus. All antiseptic precautions are to be observed. The administration of ether is frequently necessary—particularly in primiparæ the patient should be prepared as just stated in speak-



ing of the use of the vaginal tampon. The bladder is to be emptied.

For this operation I like the Sims position and speculum, since with the cervix well pulled down by means of the tenaculum the uterine cavity is most accessible.

If the canal is sufficiently open the finger is of use to partially and sometimes completely clear the uterine cavity, but I have found it nearly always necessary to finish the work with the dull curette, or to use the curette alone through a small os.

After carefully finishing the curretting I mop the cavity of the womb with absorbent cotton wet with the antiseptic solution, and held by the uterine dressing forceps, and often finish by washing the cavity with the antiseptic solution, and particularly in septic cases apply iodine afterwards. The operation is finished by washing out the vagina, cleansing the external genitals, and applying a sterilized napkin or pad.

In case of so-called incomplete abortion, where only a portion of the uterine contents have been expelled and septic symptoms occur, or some hæmorrhage or pain from time to time, and present such a condition as assures us that placental tissue or membranes are still in the uterus, we may, perhaps, maintain a waiting attitude for a little while, in some instances, but usually it will be necessary to use the mechanical means already set forth.

The after treatment of abortion in non-septic cases, where the removal of the ovum has been complete, is very simple. It is merely to keep the patient in bed for eight to ten days, to use perfect cleanliness, to make sure that the vulvar pads are antiseptically prepared, and to not forget that the period of uterine involution is as long as after full term delivery, and more apt to be incomplete.

In septic cases the treatment must vary with the conditions which may arise. The vagina should be drenched with an antiseptic solution, and intra-uterine washing may be required. I think, in properly treated cases, that complications will be most rarely seen, and it is only when the mischief has been already done that our aid will not result in practically uneventful recoveries for our patients.

I want, in conclusion, to emphasize these points: First, the extreme danger from hæmorrhage or sepsis, to which the pa-

tient suffering from abortion is liable, especially to sepsis which may lead to the involvement of the pelvic organs or tissues and to indefinite extension and continuance; and, second, that the proper treatment of many cases is surgical, and that the most rigid antiseptic measures must be employed; that the method of simply prescribing for cases of abortion, which was taught to many of us, and permitting nature to take her own time in emptying the uterus, is most dangerous; that every case of threatened abortion should be under our most watchful care either until the threatening symptoms have passed away or we are assured that the womb is safely cleared of its contents.

---

#### ANTERIOR AND POSTERIOR COLPOTOMY.

BY NEWTON M. COLLINS, M.D., ROCHESTER, N. Y.

Surgeon to the Rochester Homœopathic Hospital.

(Read before the Homœopathic Medical Society of the State of New York, Owego, N. Y., October 5, 1897.)

ANTERIOR colpotomy consists in opening the vagina between the bladder and uterus. It is comparatively new, and offers many advantages. Posterior colpotomy consists in opening the vagina between the uterus and rectum. This has been done since Simms, Emmett and Thomas demonstrated the possibility of curing abscesses under the broad ligament by opening and draining through the vagina. Of late its technique has been materially improved and its indications increased.

During the years of the so-called laparotomy craze, with its low mortality, made possible by asepsis, improved methods, the Trendelenburg posture, and drainage with the glass-tube or gauze, laparotomy was performed instead of colpotomy in many cases too weak to withstand the former operation, and life thereby sacrificed. At this period operators often removed ovaries and tubes for fear that they might become diseased, while the uterus, the cause of more symptoms, was left undisturbed. Later an effort was made with a good measure of success to save one ovary, at least, in patients operated upon during the child-bearing period. Now the consensus of opinion

is that the uterus should be removed when neither ovary can be saved. This has been so often done by the vaginal route, with so small a mortality, that it has again become a popular procedure, since the shock is less, drainage better, and there is no fear of fistula or ventral hernia.

Some surgeons still hold to the abdominal route in all cases, but their number is getting less each year, as the mortality in critical cases of acute abscess outside of the tubes and ovaries is at least 25 per cent., while with vaginal drainage and a more complete operation later, if necessary, it is less than 5 per cent. Drainage alone often cures the cases.

Abscesses outside of the tubes and ovaries are much more common than was at one time supposed, when we were taught that all pelvic disease traveled by continuity from the uterus to the tubes and ovaries. Now we know the lymphatics and blood-vessels play an important part in carrying disease within the pelvis, as elsewhere.

The important question now is, which route to choose in a given case to secure best results to patient. Operations begun by the vaginal method do not jeopardize the life of the patient even when the work has to be completed from above, as it simply provides natural drainage and makes it unnecessary to open the cul-de-sac from above for drainage, as many are now doing. When in doubt, begin from below.

No two operators agree as to the indications for colpotomy, so I will review some of the most common, hoping that a free discussion will help us in the choice of procedures and point out new positions and methods for these important operations.

First in importance are acute pelvic abscesses outside of the tubes and ovaries. These can be opened and drained with but little shock to the patient when we are able to reach them from below through the posterior cul-de-sac, but those in the broad ligament are preferably drained through the anterior cul-de-sac, care being taken not to wound the ureters.

Second.—Acute inflammatory foci, whether containing pus or serum, after opening the vagina, should be burrowed into with the finger and drained, as recommended by Henrotten, thereby preventing a more dangerous operation later, and much suffering.

Third.—Since it is much safer, colpotomy is indicated for



diagnostic purposes in place of laparotomy, when digital examination will not reveal the exact condition of tubes and ovaries.

Fourth.—Backward displacement, with adherent uterus and appendages.

Fifth.—Extra-uterine pregnancy, when the fetus lies behind the uterus with thin coverings, thus showing that the placenta is not in the way of delivery, is given as an indication by Hermann. Martin, of Berlin, after reporting fifty-six operations per vagina, recommends colpotomy only when the mass is no larger than a fist and is not attached to the wall of the pelvis, and is extra-peritoneal.

Sixth.—Other indications are small fibroids, small ovarian and dermoid cysts, and hæmatoma.

Contra-indications for colpotomy are abscesses pointing upward, large fibroids, large ovarian and dermoid cysts, tubercular appendages if they can be diagnosed, pelvic disease accompanied by appendicitis, acute or chronic, intra-peritoneal extra-uterine pregnancy, septic vagina, and a long, small vagina with immovable uterus. In the latter case conservative work on the appendages is better done from above.

The technique of anterior colpotomy is as follows: The uterus is forcibly drawn downward and backward with a volsella, and a transverse incision made at the utero-vaginal junction. When the uterus is large the excision should extend one-half inch to the side downward and outward, care being taken not to wound the uterine arteries or ureters. Separate the bladder from the uterus with the fingers up to the peritonæum, which should be divided close to the uterus. Should the operation be for conservative work on the appendages, small fibroids, or shortening the round ligaments, the fundus can be delivered through this opening, one horn at a time, either with the fingers or instruments devised for this purpose. Now using traction, the appendages and round ligaments can be brought into view and dealt with as in laparotomy. In case the appendages are all diseased, they can be removed per vagina, together with the uterus. Should vaginal fixation be the aim, the peritonæum can be opened at the will of the operator and fixation done by any one of the numerous methods now in vogue, after which the incision is closed by catgut ligatures.

*Posterior Colpotomy.*—Retracting the perinæum with a Sims's

speculum, and pulling the cervix forward with a volsella, make a longitudinal incision from the utero-vaginal junction to the rectum, or a transverse incision at the utero-vaginal fold, either with a cautery or scissors. Most of the acute abscesses mentioned should be dealt with through this opening. Imprisoned uteri and appendages are loosened previous to doing a vaginal fixation, Alexander's operation, or shortening the round ligament, thereby making these operations possible in adherent uterus, which was formerly a contra-indication for all of them. In quite a percentage of cases the ovaries and tubes can be dealt with more easily through the posterior cul-de-sac, as well as small fibroids, ovarian and dermoid cysts, extra-uterine pregnancy, acute inflammatory foci, pelvic hæmatocele. Diseased appendages, when they are beyond repair, should be removed, together with the uterus, per vagina, as in anterior colpotomy.

---

#### A FEW THOUGHTS ON THE SURGICAL PHASE OF OBSTETRICS.

BY G. MAXWELL CHRISTINE, A.M., M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Scranton, September 22, 1897.)

SINCE the determination of the causes of puerperal fever, and the adoption of the term "puerperal septicæmia" to replace that of the older and indefinite terminology, obstetrics has been lifted out of the haphazard position it once occupied and placed on a plane more in keeping with its importance.

A short time ago I delivered a woman whose labor was prolonged and difficult. The nurse attending her was one of the old-time "monthly nurses," and she had never witnessed a confinement conducted in accordance with the present advanced principles of obstetrics. It was interesting to watch the play of the old nurse's features, and hear her verbal expressions of wonderment, at the "way a woman is delivered nowadays."

Two decades have made many and great changes in obstetrics, and it is no wonder that the kindly old nurse, whose services have been rendered beyond the outskirts of medical and surgical advance, should marvel at the change. Her pot of

lard and pad of old quilt have clung to her as relics of the long ago; and she knows nothing of green soap, of hand-brush, of permanganate of potassium and oxalic acid, of creolin, of corrosive sublimate, of a Kelly pad, of absorbent cotton and sterilized dressings, of axis-traction forceps, of ether, of glass catheter, of needles and catgut, and of a large number and variety of other things necessary to complete the outfit of a modern obstetrician. She probably has heard of the trained nurse, but has not become acquainted with her nor with her methods. She believes her to be a newfangled invention of the new doctor who she thinks has gone daft on the question. But the trained nurse is typical of the changes wrought for the better in all departments of medicine, particularly of surgery.

The present age is becoming appreciative of this change, and gradually the barriers which for a long time separated the old from the new are falling, and opposition to the adoption of the best in the alleviation of human distress is ceasing before the daily demonstration of the superiority of present methods over those of the past.

Young men go out from our medical colleges, and young women from our training-schools for nurses, imbued with the teachings of those whose duty it is to be in touch with every modern advance in obstetrics; and they carry these teachings into the communities where they settle, and thus help to break down prejudice and create a demand for the modern obstetrician and trained nurse, and incidentally for modern obstetrics.

As those of us who have witnessed the past fifteen or twenty years of this process of development in the art and science of obstetrics go back in memory to the methods of the initial end of that period, we naturally make the comparison between the *then* and the *now* with a shudder at the crudities of our early practice, but with heartfelt gratitude that we have lived to witness the present state of obstetrical attainment, and to take part in its achievements.

One feature of this development impressing itself forcibly on our minds has been the close affinity gradually assuming between obstetrics and surgery; and even now, so intimate is this relationship that it will not be wondered at if the future relegates obstetrics entirely to surgery, just as appears to be the drift respecting gynæcology.



I believe that if we can divorce ourselves from the idea that the delivery of a woman in labor is entirely physiological, and become impressed with the thought that an element of traumatism almost invariably attends a case of childbirth, and that in many of its phases obstetrics is eminently surgical, we will be in a favorable frame of mind to comprehend more fully the nature of the problems obstetrics offers for study and solution.

Perhaps, as originally designed, the pregnant woman should extrude her fœtus just as easily, and with as much freedom from trauma either to her or it, as she performs the acts of defecation and micturition. Indeed, in a large sense these three functions of defecation, micturition and childbirth are analogous, in that each is performed by an organ presided over by muscular action exercising its potential at the close of a certain fairly well-defined period of time. Each of these three acts, when ideally performed, simply exercises the normal function in a normal manner, which normal performance is followed by the subsidence of the tissues to a condition of rest, without injury or impairment having happened to their integrity.

In the general disagreement between the *intended* and the *actual* in nature, woman has not arrived at that perfect state which permits her to invariably pass, without detriment to her or to her fœtus, through those phases of her existence which, evidently, it was intended should be purely and simply physiological acts, but which fate has ordained shall frequently be otherwise.

Thus, even defecation is occasionally a departure from the normal, and the act is accompanied with traumatism. And so it is with micturition; while generally easily and harmlessly performed, there are instances of injury resulting to bladder or urethra by an abnormal performance of the function. These are instances of a want of normality in an intended normal function, and are mentioned to parallel the statement that analogous interferences with normal childbirth take place all too frequently. The recognition of this traumatic element is a distinguishing feature of modern obstetrics, and the obstetrician may well be valued according to his power of discernment and his methods of practice in this respect.

No doubt many physicians are known to members of this Society who would refuse to remove a cyst of the vulva, a pro-

truding uterine polypus or a caruncle of the urinary meatus, choosing to hand these cases over to the surgeon, and yet who would have no hesitation in attending an accouchement in spite of its intensely surgical character. It need hardly be argued that the more surgical the obstetrical attendant—that is, the better informed and the more skilled he is surgically—the better fitted he is to conduct a childbirth to a successful termination.

It is unfortunate that in so many instances the pregnant woman places herself in the care of the medical man whose surgical training and skill are at a minimum, and who often tacks obstetrics on to his practice as a commercial necessity. The greater number of general practitioners recognize this, and often wish that matters were so arranged that they could transfer this class of cases over to the specialist; but they are deterred from adopting such a praiseworthy plan because of financial reasons not altogether to be despised in these times, and they go on performing services for which they are confessedly insufficiently qualified.

To bring to obstetrics the application of the surgical sense in the fullest sense of the word and completeness of the act is not given to all who essay the rôle, but there are certain surgical principles, fortunately taught by our obstetrical teachers and exemplified in their practice, that can be projected into the method of the ordinary practitioner, if he will but make the effort to study and apply them. By reason, however, of his want of surgical experience, and of the natural medical trend of his work, he is prone to wander away from these principles, and to become either very lax in their application or altogether wanting in them. Now and then he is brought face to face with the necessity for a surgical procedure in connection with an accouchement, and then he realizes the force of what is here stated, and is filled with regret that he must transfer the case to another more competent to render the required service.

Though it is here urged that, within certain limits at least, the obstetrician should be a surgeon, he must not permit himself to lapse into the error that entraps so many surgeons, of refusing to recognize and utilize the great principles underlying the practice of general medicine. The medical man need not be a surgeon, but the surgeon should always be a medical

adept, so that his surgery, while possibly of the heroic, may also be conservative when necessary.

Gynæcology owes much of its wealth of material to faulty obstetrics, and faulty obstetrics to deficient surgical knowledge and skill on the part of the average obstetrician. If this thought can be made axiomatic with the profession and is appreciated by the laity, obstetrics will be uplifted to the exalted plane justified of it.

How shall this woman be delivered in order to attain the best results? To consider her a rubber manikin and ruthlessly to extract the fœtus is not to practice the true art, nor to apply the true science of obstetrics. Nature furnishes some of the forces essential to the act, but human aid is necessary in order to assist nature, and provide protection against misdirected natural forces and the evil tendencies of negative potentials. It is truly an art to some, perhaps an inspired gift, to so guide and assist the process of accouchement that all the tissues in play shall subsequently resume their former normal state. The measure of the maternal *vis a natura* and the determination of its value, together with the scientific application of human interference or aid, constitutes the art of obstetrics, and to the conscientious obstetrician this is a delightful study. The presentation of the fœtus, the position of the uterus, the efficiency of the muscular efforts at expulsion, the relation of fœtal with parturient canal diameters, the curve of the maternal outlet, the rigidity of cervix and perinæum—these are topics which in the relation of their exemplification fill volumes; but their mere mention serves to carry our thoughts from the simple and easy over successive grades to the complex and difficult. The mechanics of obstetrics is a long chapter, and requires not only close study but careful application, for upon it depends the integrity of the parturient parts, and hence the future health and strength of the woman.

But, no matter how skilful may be this application of the mechanical principles of obstetrics, there are certain other safeguards, methods and procedures needful of observation and practice. Of these, none is of such importance as the observance of the principles of asepsis; and it has been very truly remarked that without asepsis and antisepsis the wonderful achievements of surgery in several of its branches could never



have been secured. No matter how thorough the technique of an operation, final success lies in the establishment of an impregnable bulwark between the operated tissues and disease-producing germs. It is a very simple process by which now this bulwark is erected; but how our fathers in surgery prayed for the means whereby suppuration—that great enemy to healing—could be averted! How, when “child-bed fever” would carry away women after women, or, if they lived, make of them life-long sufferers, did obstetricians yearn for an understanding of the disease, for a means of protection, and for a method of cure!

To-day the surgeon invades the cavities of the body with comparative impunity, and suppuration is no longer the common or usual terror; and the accoucheur now enters upon an attendance in a puerperal case quite certain of his ability to shield the woman from sepsis.

But the surgeon and the obstetrician do not secure these results blindly, nor through the methods of the past, but with their eyes open to the possibilities of a lapse in method and of a non-observance of the basic surgical principle—asepsis.

There is an unfortunate element of emergency about some obstetric cases that it is impossible to altogether overcome, and which prevents the application of that surgical principle to each one for which this paper is a special plea. For this the attendant may not be directly responsible; but he is responsible for dereliction in any case whose management he has time and opportunity to direct. Our books and journals abound in chapters and articles on how this principle of asepsis can be observed, and there is no need here for its full amplification. Antisepsis is, doubtless, the best introduction to asepsis, and if properly applied to doctor, patient and nurse, makes the certainty of asepsis doubly sure. Discussion is still active as to how best to secure asepsis in obstetrics, but the observant physician will arrange his own methods.

This paper is a hint, and covers only suggestive ground, and will simply refer to a method by which the practitioner may meet some of the surgical requirements of obstetrics; and thus, even if he does no more than this over that which ordinarily has been the case with him, he will have accomplished one of the great desiderata of modern obstetrics.

Let us regard our patient as a human being, to be delivered of a fetus in such manner as not to work harm either to her or it. This is the problem—apparently so easy to the superficial observer, but to the experienced obstetrician always a matter of serious and weighty consideration, and to the woman ever one of health or infirmity, of life or death.

The satchel of the obstetrician ought to be stocked with all the requisites of an aseptic surgery, and, thus armed, the attendant carries into the lying-in chamber the most effective foe we have to puerperal infection. Sepsis in a puerperal woman, as in an operative case, implies a lapse in method, and patient, nurse or doctor must be held responsible; but the most likely guilty one is the doctor. It is an offense to his pride to so accuse him; but let the number present of our obstetrical practitioners be counted who do more than the old nurse whose armamentarium was no more than a piece of soap, a basin of water and a pot of lard, and how many would be found in the count?

Traumatism in childbirth is not always preventable, but asepsis has so far reduced its evil results as to very materially lessen our dread of it.

A neglected cervical tear has been responsible for an enormous amount of misery, and there are those who advocate the immediate repair of a torn cervix. There are doubtless cases of this character in which immediate suture is advisable; and, surgically considered, perhaps all cases possible of detection ought to be coaptated by suture. A torn perinæum, and the very frequent vaginal tear, have been topics of an endless number and variety of essays, and it is universally agreed that they need prompt surgical repair. The principle that any open wound ought to be closed is a good one; but there are exceptions in that class of cases in which to close up such a wound pyogenic infection might be locked up and thus be the source of septicæmia. Judgment is needed to discern between the operable and the non-operable tears after childbirth. I must confess to a belief that some of these tears are better postponed for two or three days, when the patient shall have rallied from her shock, the parts have assumed some resemblance to the normal, and proper assistance can be procured and adequate methods adopted for the necessary surgical procedure. This

is a conservatism not generally referred to, nor perhaps frequently intelligently practiced; but the difficulties attending a careful immediate primary suturing of an extensive perineal laceration, particularly when associated with a ragged and distorted condition of the tissues, are sometimes too great to let us hope for success. Postponement for one, two or three days, permits us time for proper preparation, and the patient is finally the better for it.

Facility for operative work in obstetrics is a very important factor in determining "time when," and often the practitioner is obliged to postpone action by reason of a want of means, when otherwise he would be very prompt in the performance of his duty.

This would not occur so frequently if the obstetrician were more of a surgeon, or possessed the surgical instinct. If he did, he would go to every case so provided as to be able to cope with almost any phase of the obstetrical act.

Every surgical case has a post-operation period, divided into immediate and remote. So has every obstetrical case; but we sometimes lose sight of our patient as to remote effects, and regard our duty as done when the two weeks of our attendance are over. With the surgical idea imbuing us, we will be watchful of our patient after delivery up to that period when assurance is justified as to full recovery from the traumatisms of her labor. This post-obstetric watchfulness is not sufficiently appreciated by either the laity or the profession, but it is nevertheless an essential, and is an index of an obstetrician's sense of obligation to his patient.

Fortunately for womankind, she recovers from some of the traumatisms received in labor, but from a vast number she suffers a lifetime. The conscientious obstetrician will zealously avoid being a party to the causation or perpetuation of any of them, and to this end it will avail him much to adhere closely to the tenets of surgery, and to view obstetrics as one of its branches.

In order that the obstetrician shall be equipped for his work, he should go to his patient with all the requisites for securing asepsis, and with such instruments as he may need for emergency use. Much has been written on this subject, and only slight reference to it is necessary here. The following articles



can be put in compact form and crowded in a corner of the satchel:

2 or 3 hand-brushes and a nail-cleaner.

2 ozs. tr. green soap.

1 or 2 doz. antiseptic tablets of corrosive sublimate for solution.

2 oz. permanganate of potassium crystals.

4 oz. oxalic acid crystals.

4 oz. creolin.

4 oz. formalin.

The soap found in some houses is not fit for the hands, and may not be aseptic. The tincture of green soap is very satisfactory. With this the hands and forearms are to be scrubbed, using the hand-brush; and with the nail-cleaner the nails are to be cleansed. The hands are now to be allowed to soak in a saturated solution of permanganate of potassium, and the stain thereof removed by use of a saturated solution of oxalic acid; after which, if a sterile towel is at hand, the hands and arms are to be wiped dry. The hands can now be allowed to remain in a 1 to 1000 solution of corrosive sublimate for a few minutes and transferred to an emulsion of creolin, one-half ounce to the quart of water, after which the necessary examinations or manipulations are made.

In the satchel should be a white coat and a pair of duck trousers, which have been made sterile, by baking in an oven if no better facility offers, and these should be put on to complete the efforts at asepsis.

In the meantime, the nurse has brought the patient to one side of the bed, with the heels on the edge, and the nates on a Kelly pad as near the edge of the bed as it is possible to place her. If the nurse is competent, she should cleanse the genitals with green soap, using sterile cotton, and invading the vagina as far as possible, and then thoroughly douche the parts with creolin emulsion from a pitcher. If the bowels have not moved within two or three hours, or the urine has not been voided, it is wise to precede the above preparations by encouraging the patient to empty both rectum and bladder, using an enema, if required, for the first. Trimming of the genital hair, if growing over the labiæ, is a good plan in the effort to secure asepsis. The syringe should never be used, if it is possible to get along without it.

Beside the instruments, pelvimeter, forceps, etc., which are peculiarly obstetrical, the satchel should contain suture and ligature material, several hæmostatic clips, scissors and needles, absorbent cotton, sterilized gauze, iodoform gauze, etc., together with a compact sterilizing outfit for instruments. Lee furnishes sterilized needle threaded with gut in tubes which can be broken open when desired; and Lee's tanks of catgut, Fowler's tubes of gut, silk and silkworm-gut, provide sterile material which can be put in a corner of the satchel for ready use. Johnson & Johnson furnish compressed sterile cotton sponges, which are very handy.

Glass catheters, an infusion apparatus, an intra-uterine double-way douching tube, shot and shot compressor, tenaculi, vulsellum forceps, and tissue forceps, are a few more of the requisites of our satchel.

It all has the appearance of surgery,—the white-coated doctor, the array of basins, dressings and instruments, the uniformed or white-sheeted nurse, the patient on the bed covered with white sheet, with the Kelly pad emptying into a bucket; but this is what obstetrics has been leading up to, and it has so simplified the work that he who fits himself for it enters upon his duties decidedly more conscientiously, and is able to acquit himself more creditably in the many emergencies arising in obstetrics, than were he to adhere to old methods.

Let each practitioner who accepts a confinement case strive to master the fundamental principles of surgery, and make every possible endeavor to apply them. He will find just as much reason for so doing as in an abdominal section or a trephining.

Profitable reading on the surgery of obstetrics is furnished in the admirable work of Garrigues on this subject, and I would advise that it also be a part of the contents of the obstetric satchel, for ready reference.

---

NOTE.—Since the above was read at Scranton in September, the writer has been employing formalin, 15 to 20 drops of the 40 per cent. solution sold in the stores to the quart, as a vaginal and intra-uterine douche, with very satisfactory results. It lacks the poisonous properties of corrosive sublimate and the odor of creolin; but its irritant qualities suggest the employment of weak solutions for the uterus and vagina.

## THE PATHOLOGY OF STRICTURE OF THE MALE URETHRA.

BY CARL V. VISCHER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,  
September 21, 1897.)

It is not the object of this paper, which, of necessity, will be brief, to enter into an exhaustive discussion of the subject, but simply to call your attention to the development of a condition, if you please, that is of extremely frequent occurrence, and one which, I believe, is not uncommonly the direct cause of changes that lead, sooner or later, to the most serious consequences. This, together with the fact that stricture is only too often considered in a superficial manner—not being given the careful attention it deserves—has prompted the creation of this paper.

It may, perhaps, be well to briefly recall sufficient of the anatomy of the urethra to bring before your minds the tissues with which we have to deal. The urethra is a tube, some eight or nine inches in length, leading from the bladder to the end of the penis, serving as a drainage to the former and as a channel of escape for the seminal fluid. Its function, therefore, is twofold, it acting both as an urinary and a sexual organ. It is divided into three portions, *i.e.*, the prostatic urethra, that part leading from the bladder through the prostate gland, and which at times is spoken of as the vesical neck, and in which we find such important structures as the veru montanum, the orifices of the ejaculatory ducts, and the prostatic sinuses, into which open the ducts of the prostate gland. The membranous urethra, the only fixed portion of the canal, and which is a continuation of the former, is held in place between the two layers of the triangular ligament. This is the most muscular part of the canal, and is in close relation with Cowper's glands. Finally, the spongy or pendulous urethra, so called from the nature of the surrounding tissue and from its dependant position. This extends from the membranous urethra to the external meatus, presenting two dilatations, the pars bulbosa and the fossa navicularis, and contains numerous glands, the openings of which are known as lacunæ.



Histologically, we find the urethra composed of three coats : first, the mucous, consisting of mucous membrane continuous with that of the bladder, kidneys, and adjacent structures ; second, the submucous, composed of loose connective with some little erectile tissue ; and, finally, the muscular, consisting of both longitudinal and circular muscular fibres, which are, however, most typically developed about the prostatic and membranous portions, being scarcely more than fibrous in character when reaching the pendulous part. The vessels are derived from the pudic artery, and are largely found in the submucous coat. The nerves are continuations of the pudic, and are principally centred in the deeper portions of the canal. It is also freely supplied with lymphatic vessels.

From the construction of this canal it can be readily seen that it offers the greatest inducement for inflammatory changes, the continuation of which is favored by its physiological functions. The urethra, by virtue of its anatomy, is capable of being the seat of either a catarrhal or a suppurative inflammation, and any or all of the changes naturally following. The former variety can be dismissed with a few words, it not bearing to any important extent on the subject under consideration, simply remembering that it is a possibility for such an inflammation to spread by contiguity of tissue into the submucous or connective tissue coat, and produce a hyperplasia, which ultimately results in the formation of a stricture.

The suppurative inflammation is, in the vast majority of instances, specific, *i.e.*, gonorrhœal in character, and is from the beginning a process involving both the connective tissue and mucous coats, and as such (suppurative) is necessarily destructive rather than constructive in its tendency, the degree of destruction depending upon the virulence of the infection and the length of its duration. Hence, the more intense the infection and the more protracted the inflammation the greater the liability to stricture formation.

The epithelial lining of the mucous membrane having but to a limited degree the power of regeneration, large areas necessarily heal by the development of inflammatory tissue, which in this instance is synonymous to stricture. The subepithelial and submucous tissue being of the same nature, destructive changes result in the same manner.

In a "nutshell," then, we may say the more intense the infection the longer the period of duration, and the greater the degree of destruction the greater will be the development of scar tissue, *i.e.*, stricture. Where the inflammation passes into a chronic form it gradually assumes more and more the catarrhal nature, and this, in turn, by virtue of hypernutrition, leads to hyperplasia, which, if in the submucous coat, may ultimately result in stricture.

The development of a stricture is found to take place usually in those parts of the canal which, by virtue of its construction, favor most the localization of the inflammation; hence, in the anterior and posterior portions of the pendulous urethra.

Having thus gone over the development of stricture, we may with advantage follow out the natural course of such scar formation, which has, as is well known, an inherent tendency to contract. This being true, the size of the stricture, or, more accurately speaking, the size of the canal at the site of stricture, depends, first, upon the amount of scar tissue; second, upon the degree of contraction that has taken place; and, finally, the manner in which the scar has formed. The diminution in the size of the canal is oftentimes in inverse ratio to the amount of scar tissue. This leads us to the classification of strictures.

Strictures are best classified, first, as to the relation they bear to the canal. For example, the most common manner for their development is upon one or the other wall of the urethra, appearing as a simple thickening which may extend from a few lines to several inches in length. The cicatricial deposit here corresponds to the long axis of the canal, and during its contraction may not impinge as much upon the urethral calibre as when the scar formation is but a few lines in width, but extends about the entire circumference of the urethra. This latter variety is of rarer occurrence, though Otis argues that the former almost invariably leads to a development of scar tissue about the entire circumference, ultimately resulting then in the second or annular variety.

No matter how slight the development of scar tissue, if it infringes on the calibre of the urethra at all it acts as a point of irritation, and, doing so, gives rise to a condition of hyperæmia.

This, in turn, produces cellular hyperplasia, which more than equalizes the absorptive power of the former, and results in the increase of the existing impediment. As scar tissue is liable to subsequent changes, we find, at times, particularly when the stricture is extensive and old, the deposit of lime salts, giving rise to another variety known as the callous stricture, in contradistinction to the elastic or resilient, consisting of cicatricial tissue of more recent origin.

The changes directly due and subsequent to stricture formation are at the commencement mechanical in their character, hence depending largely, first, upon the size of the contracture, and, second, upon the length of time of its existence, probably the primary change occurring in the immediate vicinity of the scar, where, owing to contraction, an ischæmia ensues. This, naturally, has a tendency to lessen the normal tissue resistance, but is only temporary in character. The stream of water, during micturition, acting as an irritant, soon causes the opposite condition, with the tendency to an increase of the obstruction. The canal on the proximal side of the stricture soon dilates, giving rise to a development of pockets. The effect of this "back-water" necessarily sooner or later involves all the organs proximately situated to the seat of obstruction, even to the heart, as Fenwick has shown; hence in the prostate, bladder, ureters, and finally, but by no means least, in the kidneys, the continuous irritation gives rise to a chronic hyperæmia. This leads to tissue hyperplasia, with its subsequent changes; in short, to a low grade of kidney inflammation, *i.e.*, an interstitial nephritis.

I feel sure this fact is frequently overlooked as an etiological factor in the development of Bright's disease, and proves an important reason why urethral contractures deserve more careful attention than is often given.

In conclusion, we may briefly mention traumatic strictures, which are the result of wounds that are followed by the development of scar tissue, and therefore are identical in character to what we have learned to consider as organic. They are more often found in the deep urethra, for the reason that it is this portion of the canal that is mostly exposed to injuries—though, of course, they may occur at any point.

Inflammatory strictures result from infiltration of the mucous



and submucous coats accompanying an acute inflammation, therefore cannot properly be classified as belonging to strictures in the narrower sense. The spasmodic stricture—this, also, cannot be spoken of as a true stricture, it simply being a temporary narrowing or obstruction of the canal due to a spasm of the muscular coat, and is most common in the deep urethra, being caused by an organic stricture of large calibre, or by some other irritant, as acid urine, stone, etc. At times it is due to a psychological condition.

In conclusion, we may mention congenital strictures. These, with rare exceptions, occur at the meatus, and in the majority of instances are postnatal, the result of a balano-posthitis.

From what has been stated, we may thus define a stricture as an infringement upon the normal urethral calibre, due to an organic change in the wall or surrounding tissue.

---

#### CLINICAL CERTAINTIES.

BY W. S. SEARLE, M.D., BROOKLYN, N. Y.

EVERY observant practitioner gradually accumulates a fund of clinical certainties—therapeutic truths limited by no formulæ or theories—which, if collated and properly recorded, would be of incalculable value. Many, and even most of them, are really, or probably, homœopathic in their essential character, but some of them are not.

In the hope of eliciting from others much more than is herein afforded, I venture to start such a department in the *HAHNEMANNIAN* by the record of a few such facts.

*Croup.*—*Veratrum viride* is more valuable in croup than all other drugs combined. A few drops of the tincture in water, frequent teaspoonful doses during the night, and less frequent ones during the day, quickly and certainly dispose of all forms of croup except the membranous, and even in that controls both fever and spasm, thereby aiding *kali bich.* and other remedies.

*The Tongue of Veratrum Viride.*—There is a peculiar-looking tongue, not seldom seen in practice, and when it is found, *no*

matter what the disease, *verat. v.* is certain to cure. On the edges this tongue is moist and of a natural pink color (coated or not), but the central portion, from tip to root, is dry and dark red, looking as if a red-hot iron had been applied to it. A tongue like this, or any minor approach to it, positively indicates the employment of this drug.

*Black Tongue.*—A dry, blackish tongue, looking as if charcoal had been chewed, and had colored the tongue; more deeply over its central portion, and more thinly near the edges, indicates chloral hydrate.

*Sudden Clearing* of the tongue in acute disease, especially when a smooth, red surface is left, always indicates a lingering convalescence.

*Stomach Worms.*—Far better and more efficient, both as a palliative and curative, than all homœopathic remedies is the old-fashioned “Elixir Pro.” (myrrh and aloes) of our fathers. A teaspoonful of this in two tablespoons of water, well sweetened, and given before breakfast, on three successive mornings, effectually disposes of the attack, and soon eradicates the tendency.

*Stomach Worms.*—The only positive diagnostic symptom is swallowing during sleep. If it is present, worms are there. If it is absent, they are not there.

*Punctured Wounds.*—The pains and dangers that accompany wounds of this description are well known. Not so well known, however, is the fact that white-bean water—hot water poured upon common white beans—speedily and certainly cures the pain and obviates the danger. Repeated and unfailing success with this simple domestic remedy has given me the most absolute confidence in it.

*Purpuric Hæmorrhages.*—If physicians habitually inquired of their hæmorrhagic patients whether they found “black-and-blue” spots on their limbs which they could not account for, they would discover purpura much more often than they do. Of course, the serpent poisons are here the most effective remedies, and, of them, *crotalus* is most often indicated and curative.

*Biliousness.*—Always look to the urine for proof or disproof of the existence of this condition. If this secretion has a natural amber color, there is no lack of function in the liver.

The only exception is in cases of lithemia, where the excretion of uric acid is paroxysmal.

*Tape Worm.*—Light and scanty diet of fruit and milk for one day. Next morning take following mixture in one dose: Chloroform, ʒj.; Croton oil, gtt. jj.; glycerine, or mucilage of acacia, ʒj.

*The Lobule of the Ear.*—Few, if any, octogenarians exist who have not a long lobule. It goes with a solid, square-built frame, while those in whom the lobule is short or non-existent have long necks, big “Adam’s apple,” narrow chests, stooping shoulders, and the like. Of course, one with the best heredity may die early from zymotic disease. But these and accidents excepted, people live about as long as the ancestor or ancestors whom they most resemble physically. This law runs throughout nature. The plant lives after its kind. The parrot out-lives the canary ten times over, and for no reason but heredity. The length of the lobule of the ear is, therefore, always a factor in my prognoses.

*Offensive Excretions.*—It is just as true of chronic as of acute disease that the worse the patient smells, the worse he is.

*Colocynth and Staphysagria.*—When colocynth fails to entirely cure a colic or a neuralgia, which it would seem it should, follow it with staphysagria.

*Chill.*—To abort a chill give, to an adult, a teaspoonful of chloroform in a little water; to a child give proportionately less.

*Morphia, Hypodermically, in Diseases of the Heart and Kidneys.*—It is a mistake to consider the administration of this drug as contraindicated in the closing days of hopeless valvular disease. There may be exceptions, but the rule is that nothing affords so much comfort and relief. The same is true of uræmic convulsions.

*Gastric Catarrh and Ulcer.*—Fl. ext. hydrastis, gtt. xv., in water before meals.

*An Indication of Heart Disease.*—Frequent, ineffectual belching should lead the physician to examine the heart.

*Jaundice, Catarrhal.*—Large enæmas of water at 50° (F.) twice daily.

*Pain and Inflammation.*—By the administration of ferr. phos. and arnica during and after labor, as well as ferr. phos. and staphysagria before and after surgical operations, both pain and inflammation are largely avoided.



## HELPS IN CIRCUMCISION.

BY LANDRETH W. THOMPSON, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,  
September 21, 1897.)

You may find my text in the first half of an old English proverb, viz.: "A thing of beauty—" the balance of the proverb is not now under discussion, so I shall not repeat it.

My thought is not to consider the "why's" nor the "why not's" of the operation, but simply "how" it is best done, and in so doing to give rather my own personal experiences than reference to the many works of other men. As a preliminary injunction, in order to help the baby from the very beginning, the accoucheur ought himself to retract the foreskin during the first week, and at intervals thereafter. He should instruct the nurse and mother to pursue the same course. This procedure will prevent the formation of adhesions, with their subsequent train of distresses, and render unnecessary the operation of circumcision, because the foreskin, being thus habitually mobile, will never contract down in front of the glans to a pin-point opening. It will be readily kept clean, inside and out, hence will not become so rigid and thickened by inflammation as to retard the natural development of the contained organ.

We come now to the operation itself.

In the first place, as to the employment of an anæsthetic, the safest rule is to use general anæsthesia for all boys under twelve years, and for all girls—also for the spoiled fighting imps of boys (for there are such) above twelve who will not listen to reason or common sense. However, above twelve, cocaine is quite satisfactory, for it will stop all pain.

In the second place, I believe in rendering the surfaces of not only the genitals, but the surrounding parts, as nearly aseptic as possible by the vigorous use of scrubbing and bichloride before the cut is made.

In the third place, the forcible retraction of the foreskin *by the fingers alone* can and ought to be done as the first step in the operation. This is accomplished by steadying the penis by the

middle, ring and little fingers of both hands, then using the forefingers and thumbs to force the skin back. It can be done in five seconds, whereas a probe or director will require as many minutes. The secret is to hold the organ firmly outstretched with the fingers first mentioned, then to work quickly and forcibly with the others. It is really painful to watch the long, tedious efforts with a probe or director or forceps, when you know the same end can be reached instantaneously in ninety-nine cases out of the hundred. The hundredth case cannot be retracted though you used a dozen probes, for either there is newly-organized tissue, resulting from inflammation in the foreskin, which will not roll back, or a cartilaginous ring has formed which must be cut.

In the fourth place, the incision best adapted to the largest number of cases is the very plain cut, with scissors, made from the frenum to the dorsum, inclined upward on the dorsum. For reasons given below, it will be found advisable to remove considerable skin and leave the mucous membrane long in this cut. The tissues may be steadied by some clamp, like the Levis clamp, or by artery clips; but here, again, I would urge that valuable time is lost in their application, and at least in children the left hand of the operator will always hold the foreskin much more intelligently and guide the scissors more surely than any clamp devised. The mucous membrane is finally nicked at the top and the resulting dog-ears trimmed. Now you will find the advantages of cutting the skin short and leaving the mucous membrane long are that the line of union is further back from the corona, hence there is less probability of its adhesion with the more or less congested and abraded surface of the glans; also that the dressings will lie in close apposition to the line of suture; also that the two cut edges have the counter-pressure of the body of the penis beneath them, and will not, therefore, separate or curl under. It is, however, a serious error to cut *both* skin and mucous membrane short. If any vessels bleed at this stage of the operation it is much more agreeable to tie them now, with the child anesthetized, than to be called up at one or two o'clock in the morning to do it.

In the fifth place, interrupted sutures are generally better. Four or six are used in most children. But it is particularly

difficult to avoid trouble at the frenum, and for this I have employed a stitch which I have not before seen used for this particular purpose, viz.: the needle, held parallel with the penis, is introduced into the skin near the middle line; it is carried across the raw tissue and emerges from the mucous membrane on the same side of the frenum; it is carried openly across the frenum and reintroduced, this time, into the mucous membrane, down across the raw tissue, to emerge through the skin a short distance from its original point of entrance, and is then tied. This has been, in my hands, by far the most satisfactory method of securing the frenum. It gives accurate apposition, and prevents much of the swelling that occurs with other stitches. At our Children's Hospital it has been named my quadrilateral stitch.

In the sixth place, the best of all dressings is a long strip of gauze, iodoform or bichloride, cut as wide as the penis is long when slightly extended. The gauze is folded upon itself so that it will be long enough to go twice around the penis and have eight or ten layers. It is then wrapped tightly around the extended organ, and firmly bandaged or tied with another *wide* strip of gauze. It now forms what you may call a splint for the whole organ, and, as pointed out above, is placed in close apposition with the entire line of suture, thus forming the pressure to which the cylindrical body of the penis is the counter-pressure. As a consequence, there is little or no swelling, and almost all tendency to hæmorrhage is controlled. The dressings remain in position much better, and are less likely to become soiled than by any other dressing I have ever used.

The points above enumerated are largely the outcome of my experiences in our Children's Homœopathic Hospital, where many of these operations are done, and for many causes. Some are done *de novo*, others are re-circumcisions; some for specific or non-specific lesions; for deformity, natural or self-inflicted; for present disease or disease that might appear; for malnutrition or enuresis; for chorea, or to cure deviltry; in fact, it fails one to think of all the "why's" of the operation; but if the six points herein elaborated enable any of you to obtain the article named in my text, viz., "A thing of beauty," my present purpose is fully accomplished.



## THE TREATMENT OF RHEUMATOID ARTHRITIS.

BY F. MORTIMER LAWRENCE, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Phila., Nov. 11, 1897.)

THE treatment of rheumatoid arthritis, if it is to be successful, must be based upon an appreciation of the nature of the disease. Our popular nomenclature, including such terms as "rheumatic gout" and "poor man's gout," leads but too frequently to confounding the disease with chronic rheumatism, from which it differs widely, or with gout, which in its ætiology it resembles not at all. It is not my purpose to discuss *in extenso* in the present paper the probable nature of the malady; but it must be insisted upon from the start that arthritis deformans, utterly unlike gout, is a disease resulting principally from depressed nutrition. Were I asked my own belief, I would go a step further by insisting that its joint nodes and its atrophy bear no chance resemblance to the arthropathies of locomotor ataxia; that the two processes, in point of fact, are but varieties of a dystrophy whose cause lies in the nervous system. At any rate, the resemblance to many neurotic affections is seen in the marked ætiological influence of heredity, impaired nutrition and mental strain, in its frequent association with tachycardia and vaso-motor disturbances, and is further emphasized by the improvement that follows systematic attention to general hygiene and nutrition.

The first indication, then, in the treatment of rheumatoid arthritis is to build up the weakened system. A full, highly nutritious diet, with a fair proportion of nitrogenous food, is imperative. Only during the occasional acute exacerbations, and then only for a short time, is it allowable to withhold this full diet. Alcoholics are not entirely forbidden, and in some cases an occasional glass of wine or beer may be of decided service in improving the digestive functions. In addition, I habitually prescribe cod-liver oil, a teaspoonful or more after each meal; and the effect on nutrition has been most satisfactory. Should the patient, for any reason, refuse to take the oil, the free use of butter and fat meats should be insisted upon; but the results are by no means as marked.

Environment is of equal importance. Freedom from business cares and a mild, dry climate, both so essential to the treatment, are often best secured by a visit, especially during the winter months, to some such resort as the hot springs of Virginia or Arkansas. The damp air of the seaside will generally aggravate the pains of the disease, and in consequence an inland place must be chosen. It is probable that the improvement which so frequently follows a visit to one of these resorts is due to the change of climate and scene rather than to any unusual virtue of the waters. Under all circumstances, dampness, whether of air or soil, must be avoided, and woollen underclothing must be the rule throughout the year.

A great deal of attention has been paid to the use of heat, both moist and dry, in the treatment of this affection. The free use of warm baths, with or without the addition of arsenite of sodium or other chemical to the water, has many warm advocates. For the past two years, however, interest has centered in the use of dry heat. An apparatus consisting of a metallic cylinder lined with asbestos is strapped about the affected limb, and within this the temperature is raised to between 200° and 300° Fahrenheit. No distress is experienced by the patient, and the relief of pain and reduction of the swollen joints, even when the latter condition is of long standing, are said to be marked. Unfortunately the apparatus has, if I am correctly informed, been patented, and its use is under such restrictions that it will be some time before medical men will be able to judge for themselves as to the success of the method.

Electricity, used in connection with baths or independently applied to the affected joints, has been recommended; but Goodno, presumably with a thought as to the probable neurotic nature of the malady, has applied galvanism to the length of the spine for from fifteen to twenty minutes daily, and he reports that the results were decidedly beneficial. Another method, a substitute for galvanization of the entire spine, consists in the use of circuits of about six inches along the spine, the electrodes being moved frequently to avoid irritation.

Manipulation and massage, which have been used in connection with the baths, possess a great importance of their own,

and are an essential part of the treatment in any case. By the careful and persistent use of passive motion, even in cases where the disease is steadily progressing, much of the deformity can be prevented. It should be used daily.

Finally, as to drugs. A large proportion of those which have been recommended on purely theoretical grounds have, in my own experience, proven disappointing. *Actea racemosa*, which has been highly commended by Ringer, and whose symptomatology would suggest its value, has given no permanently satisfactory results. Sulphur has proven equally unreliable. *Pulsatilla* has, however, given eminently satisfactory results in several cases in which the uterine symptoms, so often associated with rheumatoid arthritis, were characteristic of the drug. *Sepia*, selected for similar reasons, has given good results. *Causticum*, carefully selected and used perseveringly in several cases, produced no noticeable improvement. *Colchicine*, however, has, in a number of cases, been followed by very marked benefit. I have used the solution, one grain to the ounce, in five-drop doses, three times daily, for periods of several months, and in at least three cases the nodes have lessened in size, the joints have become less painful, and movement has become freer. *Calcarea* I have not used, although it has been highly commended; nor have I had occasion to prescribe *sabina*, *collinsonia*, *natrum phos.*, *rhododendron*, and the many other remedies to which an occasional success has been attributed. Iodine is unquestionably a most valuable remedy; indeed, the old school, having found the salicylates perfectly useless in osteo-arthritis, have come to rely upon the iodides almost entirely in their practice. The syrup of the iodide of iron is a favorite prescription with them, and I must confess that in several cases where other remedies had failed that preparation gave most decided results.

The prognosis in rheumatoid arthritis is necessarily unfavorable only in those cases occurring in persons of advanced age. Patients of middle age, in whom the disease is not advanced, may be given a fairly hopeful prognostication. Absolute recovery is by no means rare, and in almost every case we may hope to hold the disease in check. But such a prognosis is conditional—conditional upon persistent, careful treatment along the lines that I have suggested for not weeks, but months, and even years.



## CARBUNCLE: A CASE.

BY S. G. A. BROWN, M.D., SHIPPENSBURG, PA.

THE writer presents the following case, not with an idea of introducing anything new in the field of therapeutics, nor does he expect to enlighten the many readers of this journal by producing anything astounding as regards the pathology or ætiology of the above-named disease. However, it may be expedient to refresh our memories by recalling what this affection is usually considered.

Carbuncle is a disease of advanced years, being "rarely seen in infancy or early life." It is localized, affecting chiefly the back of the neck, the buttocks, or the back. It is often associated with diabetes, more especially if occurring in the young. "It is a circumscribed, deep-seated inflammation of the skin and subcutaneous tissue," which invariably terminates in a slough. Indeed, it may truly be termed a suppurative inflammation of these parts, which become more or less gangrenous as the disease advances.

On April 28, 1897, Mr. J. F., æt. 35, single, of temperate habits, presented himself at the office with the following symptoms: General malaise; headache, occipital, quite severe; anorexia; nausea; slight elevation of temperature; dull burning pain in right lumbar region. Upon examination I found a fairly circumscribed inflammatory induration of the skin and subcutaneous cellular tissue in this region, covering an area, probably, of nine or ten square inches. He informed me that he had observed the burning sensation and had headache for two days previous to his visit to me. The skin was hot, painful to touch, and of a dark reddish hue. He was given *lachesis* internally, ordered to return home and go to bed, and hot fomentations of bichloride of mercury were applied, changing frequently day and night. The carbuncle (for such it was), however, continued to advance rapidly, so that in three or four days it had assumed a soft, spongy appearance of a deep purplish hue. Numerous small apertures now began to form in the skin; a thin and partly sanious pus began discharging, show-

ing plainly a disintegration of the subcutaneous cellular tissue. The remedy was changed to *hepar*, with an occasionally interpolated dose of *tarantula* for the atrocious pains, which were now becoming almost unbearable. Meanwhile the inflammation continued to extend in all directions. On May 6th, upon consultation with Dr. J. M. Drum, I decided to operate, as the patient was of a very nervous temperament, and was suffering excruciating pain. The carbuncle had now spread so that it covered quite an extensive surface, its diameters being about three by five inches.

After having thoroughly prepared the patient, and having observed the usual strict antiseptic precautions, the patient was anæsthetized and several crucial incisions made, after which the parts were thoroughly curetted, all dead tissue being carefully removed. The denuded surface being so extensive, the wound was then dressed by applications of iodoform gauze wrung out of a bichloride solution 1 to 1000, so that it might heal by granulation. Notwithstanding the strictest antiseptic precautions and the most careful personal attention, the carbuncle began spreading rapidly, extending upward toward the ribs and backward toward the spinal column. Suppuration continued, and the result, thus far, was anything but satisfactory to ourselves. The patient was rapidly becoming emaciated, and the exhaustion was daily more apparent. There was a slight rise of temperature. The carbuncle had now assumed an enormous size, viz., four by seven inches. The new areas were studded with small apertures, or pepper-box openings, through which thick pus exuded. We now dressed the wound by first washing and cleansing it with a solution of *succus calendula* 1 to 6, and then applying to the suppurating surface iodoform gauze wrung out of this solution. The effect was marvellous. Pus began to disappear rapidly, the inflammatory extension ceased instantly, temperature dropped, and by July 1st the wound had entirely healed. When we changed the dressings we changed the remedies, also, to *arsenicum* 3x and *hypophosphite of lime* 1x, which were given in alternation.

The extension of the inflammation after the operation was prominently indicated by a dark tortuous strip, the lower right side being the part primarily affected, and upon which the operation was performed. The part to the left showed the extension

of the inflammation. An extensive surface surrounding the carbuncle showed exfoliation of the epidermis, the cutis having been inflamed, but not to the extent of breaking down. The dimensions given are those of the denuded surface proper.

Now as regards the treatment of this dreadful disease. Are incisions ever justifiable? Dr. William Tod Helmuth says: "Ever since I have had mental fortitude enough to lay aside the routine practice of the schools and think for myself I have had my doubts with reference to these free incisions, and I have yet to discover that *decided* benefit accrued from the free incisions to prevent spreading." Yet if the theory be true that the spread of the disease is due to the micro-organisms flourishing in the sloughs, should not the *thorough curettage, followed by the most careful antiseptic treatment known*, have ended the trouble then and there? Then, again, the free incisions do not give the great relief to pain they are supposed to do. The parts do not heal as quickly. Third, *succus calendula* has done more for me as an antiseptic than any other drug. I have used it repeatedly where iodoform and the bichloride have failed, and have always had the most gratifying results. It is far superior, in my judgment, to many of the so-called antiseptics of to-day. Again, Dr. Helmuth says: "*Calendula*, from its peculiar action on suppurating surfaces, is a medicine that sooner or later must receive the attention which its virtues deserve. . . . It will be as highly in vogue after operations, in the treatment of wounds when *large and exhausting suppuration* is to be expected, as *arnica* has become in the treatment of bruises." Hoping that others may be benefited by steering clear of the blunders I have herein presented is the only excuse I have for having written this paper.

---

**INFLUENCE OF ODORS ON THE VOICE.**—Dr. Joal calls attention to the many cases recorded in medical literature of severe headaches, nervous disturbances, and even occasional cases of death, due to the inhalation of the odors of various flowers. He then states that a number of singers and actors suffer from this, and that usually it is a certain odor which the affected person cannot tolerate.

The symptoms set up are usually coryza, hoarseness even to aphonia, headache, etc. He reports a number of cases in several of which good results were obtained by cauterization of the hypertrophied mucous membrane.—*Review de Laryngology*.



LOCAL GYNÆCOLOGICAL TREATMENT AND THE INDICATIONS FOR  
REMEDIES IN GYNÆCOLOGY.

BY J. LEWIS VAN TINE, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

WITH the rapid strides of progress which gynæcology has made in the past few years there have been developed various methods and substances to be used as local measures for the relief and cure of pelvic troubles. Scientific research into the mysterious, old-fashioned "pelvic cellulitis" has brought forth the present clearly defined diseases of the female pelvic organs, so that now, in the light of modern ætiology and pathology of these diseases, we are enabled to apply treatments locally based on scientific principles, supplanting the time-honored routine of an imperfect inspection of the cervix uteri and a general swabbing of the cervix and vault of the vagina with various medicated substances. In the early days of gynæcology nitrate of silver was used upon all eroded cervices and inflammatory conditions and unrecognized lacerations of the cervix, resulting in the destruction of considerable cervical tissue. Following this, solutions of sulphate of copper became a favorite local application, in the German hospitals, for the relief of erosions and cervical catarrh. Later, Churchill's tincture of iodine became the popular remedy.

It may appear to be going beyond the scope of this subject to mention the preparation of the patient for treatment, but it is so closely related to it that it will bear consideration. In examining and treating patients it cannot be too strongly urged that the greatest care should be observed to avoid unnecessary exposure. The great aversion to examination will be strengthened to disgust by careless exposure, and women will often neglect necessary treatment as a result. Assuming that the patient is in the dorsal decubitus, covered with a sheet, the clothing can be arranged, digital and bimanual examination can be made and the speculum introduced without once raising the cover, unless there is occasion for inspecting the vulva. After introduction of the speculum the sheet can be arched around it and treatment applied without any exposure.

The tampon is one of the most important means of local treatment. It can be made of sterilized absorbent cotton or lamb's wool; the latter is preferred when a non-absorbent material is desired. It is light, very elastic, and serves as an excellent temporary support for displacements of the uterus. Absorbent cotton tampons become heavy and, at times, irritating to the patient. When a tampon is used only for support, it should be covered with carbolated vaseline, which assists in introducing it and renders it easier to remove.

The tampon should be carefully selected to fit and not over-distend the vagina. It is a good plan to make three or four sizes and select one according to the requirements of the case. The method employed by the writer in making the absorbent cotton tampons is as follows: Cut from a roll of cotton a strip six inches wide; then cut this into smaller strips two inches wide by six inches long. One, two or three of these smaller strips can be laid one upon the other until the desired thickness is obtained. This is nicked in the middle on both sides to the depth of one-half inch, and a clean piece of cotton twine tied around it. The cotton is then folded on the long diameter, and we have a tampon two by three inches suspended by the twine at the end. Other smaller tampons can be made by cutting the small strips one and three-quarter inches by five inches.

Various medicinal substances are combined with glycerine for application on the tampon. Boracic acid, hydrastis, aristol, ichthyol and tannic acid are among those most frequently used.

*Boro-glyceride* acts as an antiseptic—relieves pelvic congestion by the depleting action of the glycerine, which extracts water from the tissues.

*Hydrastis* is very useful in chronic gonorrhœal vaginitis, endocervicitis, and erosion of the cervix, with profuse yellow and stringy leucorrhœa. It is best to use the colorless extract to avoid the almost indelible stain which the other produces. Twenty-five per cent. to fifty per cent. of the extract is mixed with glycerine.

*Aristol* is used in erosion of the cervix, specific vaginitis and chancroid. It is suspended in glycerine, ʒj to fʒj. It is also used as a powder.

*Ichthyol* has recently been used for erosion of the cervix and general pelvic soreness. It can be combined with glycerine, ten per cent. to twenty-five per cent.

*Tannic acid* may be applied as a powder or glycerole, its chief action lying in its astringent properties and thereby relieving relaxation of the vagina. Pulverized alum has a similar action in the same conditions. Both are useful for erosion of the cervix with profuse leucorrhœa.

*Iodine* (Churchill's tincture) is probably the application most frequently used. It is useful in cases of chronic metritis, sub-involution, and ovaritis of the sub-acute and chronic varieties.

*Iodized phenol* (one part carbolic acid to two parts Churchill's tincture of iodine) is used in about the same conditions that iodine is used; also in erosion of the cervix and endocervicitis. When used upon the endometrium for sub-involution and chronic metritis it should be diluted with an equal portion of glycerine.

*Chromic acid*, used in the strength 5j to f5j water, has been recommended in cases of endocervicitis with stringy, albuminous discharge. This treatment should be reserved for those cases which do not yield to the milder applications, and should not be used oftener than once a week.

Treatments should not be too frequently repeated, on account of the bad mental effect upon the patient; she is led to allow her mind to dwell too much upon her condition and grows low-spirited, and despondent, and her troubles, which may be attended by but slight discomfort at first, may develop in her imagination to a disease of serious nature.

The application of pessaries to correct displacements of the uterus also comes under the head of "local treatment," but is such a broad subject that it deserves special consideration that cannot be embodied in this paper.

Our attention has thus far been directed to the local measures which can be employed for our patients, but a great and important feature of our general treatment of the case is the careful selection of the homœopathic remedy. A few of the most important remedies, with some of the indications, will be mentioned, but these and others are worthy of more careful study.

*Actea racemosa*.—Neuralgia of the ovaries and uterus, with



great tenderness and bearing down, the pains shooting up the sides and across the lower part of the abdomen. Endocervicitis with general nervous hysterical symptoms, uterus engorged, cervix hypertrophied, all the organs very sensitive, especially the ovaries.

*Belladonna*.—Inflammation of pelvic viscera. Prolapsus of uterus; inflammation of uterus; inflamed ovaries, worse right side; all with heavy dragging and forcing pain.

*Bryonia*.—Inflamed ovaries, with sharp, stitching pains. Pelvic peritonitis.

*Calc. carb.*—Endocervicitis. Constant aching in vagina. Leucorrhœa like milk, very profuse, with burning and itching.

*Chamomilla*.—Dragging from sacral region forward, with frequent urging to urinate; tearing pains in legs. Leucorrhœa acrid, watery or yellow.

*Gelsemium*.—Congestion of uterus and inflammation of ovaries, with heaviness in uterine region and melancholia.

*Helonias*.—Atonic conditions of the female organs, prolapsus with general malnutrition and mental depression; sensation of soreness and sensitiveness of uterus; the patient "is conscious that she has a womb." Offensive leucorrhœa with erosion of the cervix, which occasionally causes hæmorrhage. With local uterine symptoms of displacement or of chronic inflammation, etc., there is generally pain in the lumbar region, dull aching, sometimes weight on the chest, pressure on head. Pruritus of vulva and vagina, which are hot and swollen and exfoliate; aphthous patches. Induration of uterus.

*Kreosotum*.—Inflammations of the female sexual organs characterized by erosions and offensive excoriating discharges. Erosion of cervix with burning deep in vagina, great heat and soreness of the mucous membrane, bearing down pains and offensive acrid leucorrhœa. It is valuable as a palliative in scirrhus of the uterus and epithelioma of the pudenda, with the burning pains as from hot coals, and offensive discharge. Leucorrhœa of the peculiar odor of green corn. Pruritus of vulva with offensive moisture.

*Lilium tigrinum*.—Prolapsus of the uterus, with heaviness and pressure in pelvis, soreness and shooting pains, and a desire to press upward against vulva or hold abdominal walls. Retroversion with pressure against rectum causing ineffectual

efforts to evacuate the bowels. Profuse leucorrhœa, often excoriating and painful urination. Sharp pains in the ovarian regions. With the uterine displacements and ovarian pains we frequently find palpitation and numerous nervous symptoms about the heart; sometimes terrible pains running up the back to the vertex.

*Nux Vomica*.—Prolapsus of uterus, recent, resulting from sudden strain, associated with the bladder and bowel symptoms characteristic of this drug.

*Platinum*.—Pruritus of vagina. Nymphomania. Sexual melancholia. Prolapsus of uterus with constant pressure in back and groin. Chronic inflammation of ovaries, especially right. Albuminous leucorrhœa. With the uterine and ovarian symptoms there is usually various reflex nervous symptoms—cough, aphonia, palpitation, spasms, sleeplessness.

*Pulsatilla*.—Leucorrhœa from delayed menses, discharge thick, bland, with swollen pudenda, rarely thin and acrid. Prolapsus of uterus, worse lying down and from heat, better walking in open air, with weeping mood.

*Secale cornutum*.—Uterine displacements. Sub-involution of the uterus. Congestion and pain in the uterus and ovaries, especially right ovary.

*Sepia*.—Great dryness of vulva and vagina, painful to touch. The symptoms of pressure as if everything would protrude, and the feeling of emptiness in the stomach and abdomen, have led to the very successful use of this drug in displacements of the uterus, especially in simple prolapsus. There is a feeling as if everything would protrude from the pudenda, and the woman even crosses her legs to prevent protrusion. Induration of the neck of the uterus. Chronic endometritis, with tenderness over uterine region and constant desire to urinate. Leucorrhœa yellow or milk-like; excoriating.

*Sulphur*.—Pruritus of vulva with burning and stinging; with miliary eruption, worse from heat of bed. Prolapsus uteri with aching across sacrum; constipation. Profuse yellow, corrosive leucorrhœa. Burning in vagina, is scarcely able to keep still.

---

## BETANAPHTHOL-BISMUTH—AN IDEAL REMEDY IN DIARRHŒAL DISEASES.

BY E. G. WHINNA, M.D., PHILADELPHIA.

Physician to the Philadelphia Home for Infants.

As physician to the Philadelphia Home for Infants for the last five years, my attention has been frequently called to the ætiology and especially to the treatment of infantile diarrhœas. In an institution of this character, where large numbers of children are gathered together, the prevention and treatment of such disorders becomes especially important.

The children are taken into the home between the ages of three months and three years, and in the majority of cases the problem of artificial feeding has to be met and solved, as in very few instances can the maternal supply of nourishment be continued, the mother either being dead or finding outside employment. Thus it may be seen that we have to contend with these cases just at the time (weaning) and age (three months to two years) when they are most susceptible to gastro-enteric disorders. The simple act of weaning, if done suddenly, is almost certain to be followed by an attack of diarrhœa.

We may divide the causes of diarrhœal diseases in infants into predisposing and exciting. Under the head of predisposing we might mention *age* (under three years), improper hygiene, a weak or enfeebled constitution, and any disorder of digestion caused by improper methods of feeding or the use of improper foods. The exciting cause is something for the production of which two things are essential, heat and artificial feeding. The longer I practice the more I am becoming of the opinion that the causative elements in the great majority of cases of diarrhœal disease are some of the various forms of bacteria or their resulting products. As the Scriptures say, we should give "a reason for the faith that is within us," and this I will endeavor to do. It is usually in the warm weather, when the temperature is over 60° F., that these diseases prevail epidemically, and this is the temperature at which decomposition begins and bacteria multiply freely. Lack of cleanliness



of person, food or bottles, which we all know is a prolific cause of diarrhœa, is also a helpful agent for the propagation of the bacteria. By the frequent handling of the milk which it undergoes in its transition from the dairy to the nursing-bottle, bacteria find ready access to it, and the milk is often allowed to stand for hours at a time at a temperature sufficiently high for bacterial growth to occur. The normal discharges from an infant's bowel contain a number of bacteria, the most important of which are the *bacterium lactis*, *arogenes*, and the *bacterium coli commune*. The former lives in the upper part of the bowel and excites the fermentive process in milk; the latter is found mostly in the lower part of small intestine and in the colon, and has some influence on the digestion. In diarrhœa the number of bacteria found in the stools is enormous, as many as forty different varieties having been isolated. There is no class of diseases in which so much can be done in the way of prevention as in those of the gastro-intestinal tract. With this end in view, we should get as many children out of the city in summer as is possible, sending them to the seashore, country or mountains; or, when it is impossible for them to make protracted visits, short trips on the river, or even sitting on the river wharves in the evening, will be beneficial. The parents or attendants should be taught the importance of regularity in feeding, the danger of overfeeding, and what constitutes a proper diet for infants. Great care should be taken regarding the transportation and sale of milk; all germs should be excluded or destroyed by sterilization of the milk and scrupulous cleanliness of bottles and nipples.

In warm weather the amount of food should be decreased and the amount of drinking-water increased. Prompt attention should be given to every derangement of the bowels, no matter how trivial it may appear. Dietetic and hygienic treatment in these diseases is as important as the use of drugs. Any sensible treatment will begin with an inquiry as to its cause. If found to be dependent upon faulty food or improper methods of feeding, these evils must be corrected. If this is done, spontaneous recovery usually takes place and medication will not have to be resorted to long; whereas if the evil be kept up the case will continue in spite of the most accurately selected medication. It is important to remember that during

the acute stage of diarrhœa the digestion is practically arrested. In nursing infants the breast must be withheld as long as the inclination to vomit continues, and the thirst can be allayed by the administration of barley- or toast-water. After the stomach has been quiet eight or ten hours, nursing can be gradually resumed, making the intervals between longer and the duration of the nursing shorter than ordinary. In infants recently weaned the same abstinence is to be enforced, and a return made to the breast if possible. In hand-fed infants, where a wet-nurse cannot be procured, we must endeavor to secure the artificial food best suited to the individual case. In these cases milk should generally be withheld until the acute stage has passed, and animal broths, egg-water, etc., given in its place. After the question of feeding has been settled to the best of our ability, we think of medication. The first indication is to empty the stomach and bowels of the fermenting masses that are causing the trouble. Usually the vomiting of the child is sufficient to empty the stomach; where, however, the vomiting is ineffective and but little is ejected, stomach washing may be tried. To empty the intestines is indicated in every case, and this may be accomplished by cathartics (castor oil and calomel) for the small intestine and by irrigation for the colon. The next step is to combat the process of decomposition by intestinal antiseptics and by proper food.

The drift of opinion for some time has been toward the use of drugs which check the growth of bacteria, and the drugs which can be relied upon to influence decomposition in the lower ilium and colon must be insoluble. Those drugs which have this reputation are naphthalin and bismuth. In my experience at the home and in private practice I have tried various drugs with varying success; but it has only been recently that my attention has been called to a remedy which I have been surprised and delighted to find acts as nearly as a specific in these cases as any drug can do. I refer to betanaphthol-bismuth. This preparation contains 80 per cent. of bismuth oxide in chemical combination (not simply a mixture) with 20 per cent. of betanaphthol.

It is a light-brown powder, almost odorless and tasteless, non-caustic, and insoluble in water. In the intestinal canal the combination is broken up into naphthol and bismuth; most of

the naphthol passes off through the kidneys, while the remainder, with the bismuth, is excreted through the bowel. The therapeutic effect is twofold: first, as an antiseptic, preventing the growth of bacteria, and, second, as an astringent, on account of the presence of the bismuth.

The dosage varies according to the age of patient and severity of the attack. For adults, 20 to 80 grains can be given daily in doses of 5 to 10 grains. For children, the dose is 2 to 5 grains, best administered in cold water or some simple syrup, and repeated as often as may be necessary.

One of the great beauties of this preparation is the fact that it never causes vomiting, even with the most irritable stomach; indeed, it seems to be rather a sedative to the nerves of the stomach. Of course, the use of bismuth in diarrhœal diseases is almost as old as medicine itself, but I have no hesitation in saying that of all the preparations of bismuth now in use none of them can begin to compare with the combination of beta-naphthol-bismuth. So firmly are we convinced of its value at the Home that it is always the first and, usually, the only remedy given our cases of diarrhœa. I have also been favorably impressed with its use in the diarrhœas of consumptives, as it promptly checks the frequent loose discharges, thus lessening the drain on the already weakened system, and giving the poor sufferer decided relief. In these cases it is sometimes necessary to give quite large doses, as much as 80 grains daily often being required. The administration of the drug may be continued for a long time, as it causes no injurious effects.

---

HÆMOGLOBIN AND THE RED AND WHITE BLOOD CORPUSCLES IN PREGNANCY AND THE PUERPERAL PERIOD.—Wild has observed a slight increase of hæmoglobin and of the number of the red corpuscles and a very considerable increase of the white corpuscles as compared with the red in the last weeks of pregnancy. A diminution of the hæmoglobin and the red corpuscles—the latter in much smaller proportion—follows labor, and is to be attributed to the physiological loss of blood. The slighter diminution of the red corpuscles is to be attributed to their new formation. Both constituents of the blood increase again in the puerperal period. The number of the white corpuscles reaches its highest period soon after labor, and diminishes again in the puerperal state. Nursing has a favorable effect on the regeneration of blood. —*Archiv für Gynakologie*, vol. 53, H. 2, 1897.



## EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

## CAUSA CAUSARUM.

THE subjects of Hospital and Dispensary Abuse and of Medical Charity still continue to agitate the medical mind, and we fear will continue so to do for some little while to come. Taken in connection with the disproportionate increase in the number of physicians annually turned out by the ever-increasing medical colleges throughout the land, it becomes a subject not only of theoretical but of decidedly practical importance. Some one has calculated that if the number of the insane continue to increase as it has done during the last few decades, by about the year 2000 A.D., there will be no further need of insane hospitals, for there will be no sane persons left to control them. A similar calculation, based upon the yearly increase of physicians and decrease of paying patients, would, we think, show that at no very distant period the unattached, private physician, as a distinct species, will become extinct. Indeed, we believe that in some communities this is even now the case, all the physicians having become either professors or members of hospital staffs.

What are we going to do about it? Medical societies everywhere are seeking to stay the progress of events, and put off the evil day, by whereases and resolutions. In several cases legislation has been invoked, and bills have been framed and not passed, or vetoed, if passed, and fresh attempts are again being made in the same direction.

As usual, we are against legislation. This is a matter which lies beyond and outside the reach of legislation. Any such must appear to the public as class legislation, and in no way different from the various attempts legally to protect labor-movements, boycotts, strikes, and such curses of our time. No one can successfully deny the trades'-union spirit underlying the whole of the late medical reform movement. If the dear

public is to be protected from unskillful practitioners, and if a certain course of study and certain facilities enjoyed are to constitute an index of skill, then surely the same dear public should be allowed to go to those whom special study and hospital training have supposedly made most skillful. But the interests of the dear public are not the primary consideration.

The estimation of the extent to which medical charity is abused varies considerably according to the position occupied by the maker of the estimate. That it does exist, and that to a great extent—to an extent which is not only detrimental to the interests of private physicians, but also to the morality of the community—is a fact which cannot be denied, and that it should in some way or other be limited, is therefore a self-evident proposition.

We ourselves see in the condition, as it at present exists, nothing but a natural and necessary consequence of factors for which the medical profession is itself responsible, and these are the loss of prestige by the general practitioner and the sometimes excessive fees of specialists.

We have educated the public to a belief in specialism as a fundamental article of their medical creed. In the beginning of the specialist fad, not so many years back, when comparatively few post-graduates went abroad to enjoy facilities they had not had here, and to perfect themselves in some particular line of study, it was natural that, on their return, their services should be sought by the wealthy and exclusive, and by those who felt able to help reimburse them for the expenses incurred. The foreign-trained specialist was, in those days, an article which seemed cheap at any price, and his fees were set at a correspondingly high figure. The more that was demanded, the more valuable seemed his services. It soon became the fashion among the wealthy to employ as many specialists as there are organs in the body, and where there is money to pay the piper, a pretty harmony these organs keep playing, under the *tactus eruditus* of the master specialist.

Either from conscientious motives, or from timidity, or from scientific modesty, aided by a *vis a tergo* from his clientele, the general practitioner has been too ready to divide his responsibility in dangerous or difficult cases with a specialist. It is the natural course of all ideas gradually to percolate through

the whole mass of the people, if favorable circumstances exist, or fostering influences are created, and the more surely if these ideas originate among the so-called higher classes. The idea of the necessity of specialty-attention has taken firm hold of the people. In ante-specialistic times our dispensaries served to encourage confidence in the medical profession as a whole as thoroughly furnished for all good works, the only exception perhaps being in cases of easily recognized surgical diseases. Now how different. The diseased organism reports at the central office to the distributing agency, and, presto, its *disjecta membra* go floating through the corridors of the dispensary, lashed for a time to the desk, now of this specialist, now of that one, until finally they may go forth healed and reunited, not knowing who did it, convinced of this fact only, that it required the united wisdom of several specialists to accomplish it; a fact of which it does not cease to boast to its sympathizing neighbors. They carry the thought with them, and disseminate their belief that when any ailment seems to attack a particular organ only a specialist can do justice to it. But specialists' fees are too high for them, even for those in moderate circumstances, and what more natural than that they should seek the aid they require where they can obtain it for nothing? What will not a man give for his life? We have heard of instances where men, and women, too, have been willing even to lie, or to act a lie, for the sake of their lives. Can we expect anything better of humanity as a whole? Not everyone is born endowed by nature with a hatchet and Washington's disposition.

Here comes in, too, a consideration of the relativity of the terms so often used in discussing this question. "Able to pay a reasonable fee," "in moderate circumstances," "services of a specialist," etc., etc., are terms capable of various definitions. Business men and economists maintain that the amount of rent paid, either for a dwelling or store, should never exceed a certain fixed portion of the income,—but no one has determined what should be the proportion of earnings set aside, if only in one's mind, for possible or probable medical attendance. Frequently, in our earlier days, we have been paid by thrifty Germans for the new baby as promptly as if it had been marked C. O. D., and have found that during her pregnancy the mother had put



away, day by day, or week by week, small sums to meet the occasion. Such instances are not as frequent nowadays; the babies seem to be marked I. O. U., and the whole current of possible savings sets in the direction of installment houses and building associations, so that there is no provision for sickness, a dire contingency which every one hopes to escape,—or, to have treated for nothing at the dispensary by specialists.

What proportion of a man's earnings should he be willing or able to give for medical attendance? It is impossible to say, and yet much of the harsh criticism accorded to dispensary-frequenters would fall to the ground were this idea of proportion kept in view. Let those who speak of a "reasonable fee," and "moderate charges," and "the services of a specialist," as a mere matter of curiosity and abstract mathematics, figure out how much they would have to pay for medical services if they paid the same proportion of their income as do their less-favored brethren.

We willingly grant that the specialist has a legitimate right to charge more for his services, both because they are those of an expert, and because, from a purely commercial point of view, he has more capital invested in the accessories belonging to his specialty; but we think regard should always be had to the intrinsic value of the individual service rendered in making the charges.

Let people in moderate circumstances feel that they can have the service of a specialist at a cost within their reach, and they will much prefer a private consultation to one at the dispensary or hospital.

We trust that we may not be charged with hostility to specialism or to specialists when we say that we think the key to the whole situation lies in educating the public to a proper appreciation of the capabilities of the general practitioner. Let this latter one "magnify his office," let him strive, not to know all things, but to know enough of everything to be able to recognize the justifiable limits of his knowledge. Based upon this knowledge, let him not be too ready to shirk responsibility by calling in counsel; but, when necessary to do so, let him not send his patient to charitable institutions to get, for nothing, what he knows could and should be paid for. Where, from his individual knowledge

of the circumstances of his patient, he feels that a reduction from the usual fee is called for, let him ask for such from the specialist, who in the majority of cases will be found ready to grant it. While we cannot hope that this course of conduct will entirely remove the abuses complained of, we feel sure that, besides giving the specialist an opportunity to feel the public pulse in the matter of his charges, it would go far towards limiting the number of those who now claim services at the dispensaries not intended for them.

It would work no harm even in those cases where clinical material is needed; for, alas! Fate is not niggardly in dispensing troubles to the poor, and from amongst those worthy objects of medical charity enough can always be found to supply the needs of the most exacting curriculum.

---

**SURGICAL HINTS.**—When you advise a patient to wear a suspensory bandage, tell him to get the kind which has straps running from the posterior band of the bag itself, around the thighs or buttocks. The supensories which are attached to the belt in front alone, with an elastic in the back edge of the bag, are useless.

A few drops of strong ammonia water added to the water in which you wash will greatly facilitate the removal of grease and of blood. About half a tea-spoonful to an ordinary basin of water will be the right proportion. Of course, use soap as well.

Gastrostomy is often followed by septic bronchitis, or broncho-pneumonia, due probably to the inspiration of secretions, which the œsophageal-narrowing prevents the patient from swallowing. The operation can be very well done under cocaine or eucaine, and this danger thus avoided. It is only necessary to cocainize the skin, since work on the viscera which are involved is not apt to cause pain.

When a patient comes to you with enlarged lymphnodes of the neck, be sure to examine the throat most carefully. If the patient is a child, remember that a very common cause of lymphnode inflammation is the presence of hypertrophied tonsils, or of adenoid vegetations. In an individual of middle age, examine any hypertrophy critically, bearing in mind the possibility of neoplasm.

The anæsthetic is very often as much or more to be feared than the operation. This is especially so in the case of old persons and those who suffer from chronic or acute lung, heart or kidney disease. The greatest care should be taken that no more of the narcotic than is absolutely needed should be used. Oftener than is admitted, death from the anæsthetic is due to lack of care or experience on the part of the anæsthetist. When you are about to operate upon an individual who will probably take general narcosis badly, try local anæsthesia. You will often be surprised at the apparently formidable operations which may be done with the aid of cocaine or eucaine.—*International Journal of Surgery.*

## GLEANINGS.

---

**CHRONIC INTERSTITIAL NEPHRITIS DURING CHILDHOOD.**—Dr. L. G. Guthrie, from seven cases of this variety of nephritis, which is rare in childhood, and from his personal experience, states that, anatomico-pathologically, it corresponds wholly to the granular renal atrophy of advanced age. The symptoms are likewise very similar, for there are emaciation, weariness, anæmia, polyuria, etc. Great pigmentation of the skin is often strikingly apparent, so much so as to resemble that of Addison's disease. The mucous membranes, however, remain unaffected. Cardiac hypertrophy and high tension of the pulse are very frequent, yet they may be absent. Œdema of renal origin is rare. Retinitis has not been observed. The rest of the symptomatology does not notably differ from that of this variety of nephritis in adults. As to the causes, there is a certain number which follow scarlet fever, while others depend on ascending causes, as renal lithiasis. He thinks that in many cases it is an acute interstitial nephritis from cold which becomes chronic.—*Annales del Circulo Medico Argentino*, tom. xx., No. 15.

Goodno—*Practice of Medicine*, vol. ii., p. 404—is inclined to think that the frequency of this form of Bright's disease in children is greater than is generally supposed, on account of post-mortem examinations being only recently more generally made. He goes on to state that he and the late Dr. Oatley made necropsies upon two cases in young persons, seven and nine years of age respectively, in which the kidneys were typically cirrhotic. . . . Acute infectious diseases may develop cirrhotic kidneys, especially scarlatina, rheumatic fever, malaria and syphilis. Slight nephritic changes are developed, which subside, but do not disappear, becoming finally established as chronic processes.

A. Brault, at the Twelfth International Medical Congress, gave an interesting review of the clinical division of the different varieties of nephritis.

I can find nowhere an acute interstitial nephritis described, though I have seen it mentioned.

Traube asserted that there was no such a thing as a parenchymatous nephritis, but that all inflammations of the kidney originated in the interstitial tissue.

**HÆMATURIA FROM HEALTHY KIDNEYS.**—Prof. G. Klemperer first called attention to the well-known fact that hæmorrhages may occur from perfectly healthy organs in hysteric and neurasthenic subjects, as, for example, in a case of his of hæmoptysis and hæmatemesis where, death occurring shortly after from other causes, the stomach and lungs were found to be wholly normal. He then refers to two cases of hæmaturia from healthy kidneys, where in one case, from a repetition of hæmorrhages which extended over a number of years, the bleeding organ was extirpated, and found to be entirely normal. The other case recovered under hydropathic treatment. He also observed two transient renal hæmorrhages from over-exertion—horseback and bicycle-riding.



He explains these hæmorrhages from normal kidneys as due to an anglo-neurotic hæmorrhage, a paralysis of the vaso-constrictor nerves with dilation of the blood-vessels and resultant hyperæmia, and immigration of the red-blood corpuscles.—*Norsk Magazin for Lægevidenskaben*, No. 12, 1897.

INDURATED CHANCRE OF THE TONSIL.—Dr. Wróblewski was consulted by a woman of 42 years, who had been in very good health, and not a member of a syphilitic family, and who presented on the inner surface of the swollen left tonsil a superficial ulceration which was covered with yellowish-gray, false membranes, which extended to the posterior faucial pillar. The anterior pillar was infiltrated, hard, and of a dark-red color; the cervical and supra-clavicular glands were enlarged and indurated. On account of the inefficacy of specific treatment at first, a neoplasm was thought of, but with continuance of antisyphilitic measures it disappeared in six months. Several years later there formed on the posterior wall of the pharynx a gumma, as well as two more on the arm, which yielded to specific treatment.—*Przeglad Chirurgiczny*, tom. iii., Zeszyt 3, 1897.

Dr. Bieck, at a recent meeting of the Society of Physicians of the Charité Hospital, of Berlin, presented a number of patients with extragenital chancres, one of which was on the tonsil. Here the primary sclerosis appeared as a papula of the mucous membrane without decided infiltration of the surrounding tissue. It was regularly unilateral, with considerable swelling of the submaxillary glands. During the past year there have been observed in the female wards of the Charité, fifteen cases of extragenital chancre, several of which were situated on the tonsils. The others were chiefly on the anus, the mouth and the breasts.

CONSTIPATION OF ONE MONTH'S DURATION.—Dr. Dranitzin relates the case of a boy of nine years who, for thirty days, had no passage from his bowels, and, nevertheless, felt well and had a good appetite. During the last days he vomited a few times and complained of pain in his epigastrium. When Dranitzin saw him his abdomen measured eighty-two cms. in circumference, and the rectum was filled with a massive fecal tumor. The fæces were removed partly by means of instruments, partly by the fingers, when several spontaneous passages followed. In three days the boy passed twenty-three and a half pounds of fæces, and his abdominal circumference sank to fifty-nine cms.—*Wiener Medizinische Presse*, No. 51, 1897.

FRANK H. PRITCHARD, M.D.

SYMPTOMATOLOGY OF NEURASTHENIA.—Dr. L. Joseph, who contributes an interesting article to the *Deut. Med. Ztg.*, No. 39, 1897, on the symptomatology of neurasthenia, regards three symptoms as especially characteristic, viz., general bodily weakness, pains in the most diverse parts of the body, and insomnia. Debility, he believes, is present in every case; walking and the maintenance of the upright posture, as well as movements of the upper extremities, manual work, writing, are laborious. Frequently, there is a loss of memory, relating especially to present events; and another striking feature of these cases is the depressed mental state, which often varies greatly in the course of a day. The pains are mainly localized about the large joints and occasionally are very intense. They not only affect the large nerve trunks, but also the skin and bones. The so-called points douloureux differ greatly in

size, painful on superficially touching the skin, the pain subsiding when deep pressure is made. They are frequently found on the thigh, at the apex of Scarpa's triangle, at the internal condyle of the femur over the middle of the tibia, the under surface of the os calcis, the point of attachment of the deltoid. The spinous processes of the vertebræ, the line of the sagittal suture, and occasionally the points of emergence of the cranial nerves are painful. Sleeplessness is one of the most distressing symptoms. The patients sleep for a few hours, but are awakened by the slightest noise, and are then unable to sleep again. Dreams are frequent. Sedatives, as well as bromides, are of little value, and trional is regarded as the best remedy.

**ATYPICAL GOUT.**—While the statement is often made that few cases of typical gout are seen in this country, the other manifestations of the uric acid diathesis are quite frequent. The complex of symptoms, termed *neurasthenia* by Beard, is so often encountered as almost to justify the name applied to it by some authors of the "American disease." In the study of the pathology of this condition, it has been found that the presence of an excess of uric acid in the blood and tissue fluids is the fundamental cause in a considerable number of cases. The deficient elimination and accumulation of this substance in the body reacts especially upon the nervous system, as is shown by the vague pains and neuralgias experienced by these patients and their mental state. As regards the treatment, aside from the adoption of appropriate hygienic and dietetic measures, some drug is required which will aid in the elimination of uric acid. There are large numbers of such remedies, but the one which commends itself to many physicians, by reason of its efficiency, safety and agreeableness, is *lycetol*, in five-grain doses three times daily. That this drug actually increases the excretion of uric acid has been shown by numerous examinations of the urine during its administration. *Lycetol* should be given in an abundance of water, or in the form of the *lycetol* gout water, which is both pleasant and convenient.

W. D. CARTER, M.D.

**DISINFECTION OF THE SICK-ROOM AND CLOTHING.**—(Dr. J. R. Wood.) Beginning with the appliances which can be easily extemporized, it is well to first mention a simple and cheap process for the simultaneous generation of chlorine and sulphurous acid gases. Mix a teaspoonful of dry hyposulphite of soda with the same amount of chlorate of potassa, in a cup or dish; then, as needed, drop strong hydrochloric acid on these chemicals. Do not keep them on hand mixed, as an explosion might result. The use of carbolic acid and creosote for fumigation is convenient and very manageable. The creosolene vaporizer may be used, but a small amount of creosote and carbolic acid combined with a few crystals of menthol and thymol, placed in a small tin pail and hung some distance above a gas-jet or lamp, has proved of considerable value in several maladies besides diphtheria.

Three or four feet of fine platinum wire may be kept in the physician's medical bag, together with two or three ounces of wood alcohol. A few strands of loose cotton cord may be placed in a low bottle; the platinum wire is made into a coil by winding it around a pencil; then the ends are inserted into the wick. Light the lamp, and, as soon as the wire reaches a red heat, extinguish the flame, and, if it has been properly placed above the wick, the wire coil will continue to glow sometimes for hours, and constantly generate formaldehyde gas, which can be recognized at once by the peculiar odor.

F. WALTER BRIERLY, M.D.

THE SURGICAL ASPECT OF THE PATHOLOGY OF TUBERCULOSIS OF THE BONES AND JOINTS.—Nichols (Boston) offers the following summary in a paper with the above title:

Many observations prove that tubercular disease of the bones and joints is caused by the tubercle bacillus.

Injuries of moderate severity favor the production of the disease.

In the bones the disease begins in the epiphysis, and is more extensive than appears on gross examination. Hence, in operations for removal of the disease, a considerable margin of apparently healthy bone must be removed.

Tuberculosis of the joints is generally, if not always, secondary to tubercular disease in the epiphysis of an adjacent bone.

Abscess formation is due to extension of the tubercular process to the soft parts. The contents and wall of a tubercular abscess are different from those of infectious abscesses. Partial removal of the abscess wall is harmful.

Repair is caused by the formation of fibrous tissue, which replaces and partly encapsulates the tubercular tissue. Repair may be incomplete. Fibrous tissue may produce fibrous ankylosis, or the tissue may become ossified and lead to bony ankylosis.

Paraplegia in Pott's disease is rarely due to direct bony pressure. Usually the pressure is caused by tubercular peripachy-meningitis. Rarely the pressure causes degeneration of the cord.—*Boston Medical and Surgical Journal*.

SURGICAL TREATMENT OF ACUTE RHEUMATIC ARTHRITIS.—In the opinion of O'Connor (Buenos Ayres) acute rheumatism is primarily a joint affection, due to some morbid material conveyed by the blood; that this poison—be it germ, ptomaine or ferment—gains admission to the human body through the tonsil or through one of the many doors open to such intruders; that the joint invasion is promptly followed by a form of acute arthritis with general toxæmia, and, furthermore, the infected joints serve as incubators, where the poison is elaborated and poured into the circulation, and by this latter agency conveyed to other articulations and to the heart. And in some cases the joints retain the virus in a latent form until some chill, etc., rouses it into activity. Holding such views, O'Connor feels it necessary to suggest that the term acute infective arthritis be substituted for acute rheumatism; the latter in reality is a vague expression, with little or no ætiological or pathological significance, and the prefixes, gonorrhœal, pyæmic, tubercular, syphilitic, etc., may be conveniently retained in order to differentiate the arthritis peculiar to each. Gonorrhœal arthritis and pyæmia bear resemblance in many respects, and O'Connor finds that the only successful treatment for a gonorrhœal or pyæmic joint is to immediately open, irrigate and drain it.

He then reports a case where a two inch incision made into a knee-joint liberated four ounces of greenish, turbid, flocculent serum, with many large masses of lymph. The information derived from this case was (*a*) that arthrotomy had an immediate curative effect on the arthritis of the knee; (*b*) that this arthritis is amenable to surgical treatment; (*c*) that the general toxæmia disappears when once the infected joints are opened, the morbid material cleared away, and drainage provided; and (*d*) no patient, however ill, suffering from acute infective arthritis, should be permitted to die without giving him a surgical chance.



Operate as soon as possible after the disease has declared itself (by causing swelling or effusion in a joint) ; do not wait for other joints, or for the heart, to confirm the diagnosis ; if operation is to be curative, as in pyæmia, the sooner done the better.

When more than one joint is found affected, operation should be at once undertaken, even if the heart has been already attacked. No good can come from allowing the infected joints to continue as incubators for the virus, for our object ought to be to save the endocardium from further destruction, to protect the non-infected joints, and, if possible, eliminate the poison from the system, as well as cure the infected joints themselves.

The incision must be large enough to admit the index finger, for lymph coagula fasten in the recesses of joints, and it has been frequently noted that nothing short of digital shifting suffices to detach them. It is needless to say, if such plastic stuff should be left behind, the operation would be robbed of half its value.

Irrigation should always be carried out ; without it, the toilet of the joint would be incomplete ; O'Connor's favorite injection being biniodide of mercury solution, 1 in 5000. Care must be taken to leave the joint cavity dry ; nothing effects this better than a long roll of gauze, which can be packed in, in all directions, twisted about, and when removed many flocculi will be seen attached to it. Last, and by no means least, drainage must be provided for ; never open a joint for any form of effusion unless prepared to drain it ; rest and relief of tension, as afforded by a few strands of gauze, are absolutely necessary in order to insure a good result.—*Annals of Surgery*.

HERBERT L. NORTHROP, M.D.

AN EXPEDIENT TO DETERMINE POSITIVELY WHETHER A COMMUNICATION EXISTS BETWEEN FISTULOUS OPENINGS IN THE LUMBAR OR HYPOGASTRIC REGION AND THE BLADDER OR KIDNEY.—Dr. Horwitz administers a capsule containing a grain of methylene-blue at bedtime. In the morning the dressings over the fistulous opening will be found stained blue, if there is any communication with the kidney or bladder.—*Medical and Surgical Reporter*, December 4, 1897.

COCAINE ANÆSTHESIA IN PERINEORRHAPHY.—The maximum quantity of a two-per-cent. solution was fifty minims, giving a minimum dose of one grain of cocaine. By using cocaine we avoid the prolonged vomiting that so frequently follows the use of chloroform or ether, with the great strain and irritation of the parts operated, which frequently results in failure to obtain union. I have frequently been asked if the infiltration of the parts did not interfere with primary union. I have never seen such interference. The line of union heals most promptly, without local or general reaction. Thirty minutes before the operation give the patient one-half ounce of whiskey or brandy, to be followed by a hypodermic injection of a thirtieth of a grain of strychnia. The usual strict precautions should be taken to make the field of operation aseptic. A sterile and fresh solution of cocaine must be used. My plan is to have a number of two-drachm vials sterilized ; then place in each vial two and a half grains of Merck's or Squibb's cocaine hydrochlorate. The bottles are sealed, and when a solution is required boiled water is added. The length of the needle is also of importance. Make as few punctures as possible.—Dr. W. H. Humiston, in *Virginia Medical Semi-Monthly*.

**REPLACEMENT OF THE RETROVERTED UTERUS.**—Having put the method to severe and repeated tests, I submit it to the profession with the fullest confidence in its simplicity and effectiveness. It is briefly as follows: (1) Put the patient on the back, with the shoulders slightly elevated and the knees drawn up, and, if convenient, supported by legholders, so as to relax the abdominal walls; insert a Hodge pessary corresponding to the size and shape of the vagina, being sure to carry the posterior part back of the cervix. (2) Introduce the index finger into the vagina above the anterior bar of the pessary, which will pass between the index and middle finger, up to the digital commissure; crowd the pessary gently, but firmly, backward, horizontally against the rectum, so as to pass the posterior bar well back of the fundus before exercising leverage. (3) Hold the pessary firmly against the rectum; place the tip of the right index against the anterior surface of the cervix, and push backward, while, with the digital commissure, the anterior bar of the pessary is crowded backward and downward, so as to exert leverage on the fundus and carry it upward and forward, when it is caught by the fingers of the left hand, bearing down the abdominal wall along the hollow of the sacrum, and brought forward into exaggerated anteversion. If reposition is likely to be unusually difficult proceed as in (1), but modify the subsequent procedure as follows: (2a) Carry a bullet forceps above the anterior bar of the pessary into the vagina and catch the anterior lip of the cervix securely; introduce the right index finger into the vagina beside the bullet forceps. (3) With the digital commissure crowd the pessary horizontally backward, while with the bullet forceps in the left hand the cervix is drawn forward and downward: holding the pessary and forceps in position, place the tip of the right index finger against the anterior face of the cervix just above and resting on the jaws of the forceps; then, with the tip of the index finger exerting backward pressure on the cervix and downward pressure on the bullet forceps, and with the digital commissure exerting backward and downward pressure on the anterior bar of the pessary, seize and bring forward the fundus as in (3).—W. A. Briggs, M.D., in *Occidental Medical Times*.

**THE TREATMENT OF FEMALE DISEASES.**—Dr. A. H. P. Leuf, writing from the standpoint of an old-school practitioner, says: "If asked to name the drug most serviceable in the treatment of diseases peculiar to women, or secondary to affections of her genital organs, it would be the tincture of cimicifuga. The vertexical headache, so common to these troubles, is promptly relieved by it. It may be given in from five- to ten- or even twenty-drop doses every one or two hours, until the desired effect is produced, and thereafter continued as occasion requires. The mental disturbance of female disease, of pregnancy, and of the menopause, yield remarkably to its use. It sometimes accomplishes the happiest and most unlooked-for results.

Next to cimicifuga, I believe that the tincture of pulsatilla is one of the most efficient agents for the relief of the aching pain incident to female intra-pelvic disease, especially if ovarian. In one- to five-drop doses every hour it soon gives complete relief, sometimes acting as promptly as an opiate, but without a single objectionable accompaniment or after-effect. The relief it causes has the added advantage of being curative instead of palliative, as is the rule with opiates.—*Medical Council*.

F. WALTER BRIERLY, M.D.

**TREATMENT OF CANCER BY CZERNY AND TRUNECEK.**—This consists in painting a new growth, after careful cleansing of the surface of the tumor, with a mixture of 1 gramme arsenious acid, in 75 grammes ethyl alcohol and 75 grammes distilled water. The daily use of this should form a scab which gradually grows harder and thicker; when the scab no longer forms the growth is cured.—*Beiträge zur Klin. Chirurgie.* Bd. xviii. Hft. 3.

**A CASE OF PTYALISM IN CONSEQUENCE OF RETROFLECTION OF A GRAVID UTERUS.**—Audebert. Severe salivation commenced in the first month of pregnancy, patient having the mouth always full of water. The amount of saliva averaged a litre of water per day, in consequence of which disturbances of digestion occurred and the patient became emaciated and could only take fluid nourishment. She was also sleepless. Examination showed the uterus to be in extreme retroflexion. The organ was replaced, knee-elbow position, and retained by an iodoform gauze tampon. The secretion of saliva immediately diminished and on the third day became normal. Disturbances of digestion disappeared with the ptyalism, and the further course of the pregnancy was normal.—*Gaz. Hebdom de Med. et de Chir.*, 1897, No. 58.

**THE PHYSIOLOGICAL EFFECTS OF CASTRATION IN WOMEN.**—F. Jayle, as assistant in Pozzi's poliklinik at the Hospital Broca, has examined about three hundred women castrated since 1892, but was only able to obtain information of value in seventy-four cases, which he summarizes as follows:

- (a) The disturbances are constant in bilateral ovarian castration.
- (b) The degree of development depends on the age, constitution and predisposition of the patient.
- (c) Exceptions from this rule are only found under peculiar circumstances, such as a supplementary ovary and apparently complete extirpation which proved to be an error in observation.
- (d) These sequellæ are very annoying, both to the patient and those about her.
- (e) Their duration is long; much longer than has been believed, and they appear in spite of any treatment.
- (f) After simple uterine castration they may be occasionally absent and as a rule are less marked. If it were possible to extirpate the uterus without interfering with the nervous or vascular supply of the ovaries they would be perhaps very limited.

The introduction of these conclusions into practice would lead to the following surgical rules:

- (a) A total removal of both ovaries should be a last resort, that should be accompanied always by removal of the uterus and the tubes.
- (b) If the tubes and the uterus can be preserved, resection of the ovaries should be preferred to complete extirpation.
- (c) If in the course of an operation the tubes and ovaries are extirpated the uterus should be removed at the same time.
- (d) If the tubes alone are diseased, the ovaries and uterus should be preserved.
- (e) If the uterus is diseased, the uterus alone, or the uterus and tubes should be removed, but the ovaries preserved—in other words, before everything preserve the ovaries.—*Monatsschrift für Geburtshülfe und Gynäkologie.* Bd. vi. Heft. 6, December, 1897.

GEORGE R. SOUTHWICK, M.D.



**REMOVAL OF A FOREIGN BODY FROM THE TRACHEA BY INTUBATION.**—At the meeting of the Société Médicale des Hôpitaux, of Paris, on October 29th, what appears to be the first case of removal of a foreign body from the trachea by intubation was related by M. Sevestre for M. Bonnus. A child, aged five years, put a bead in her mouth, which passed into the larynx. Attacks of suffocation with cough lasting for about an hour, and terminating with bloody expectoration, occurred from time to time.

During these, at the end of expiration, a distinct sound could be heard which appeared to be due to the shock of a foreign body.

At the end of a month the child was admitted to hospital. At the time there were no symptoms. On the third day whilst she was being lifted, a violent attack of suffocation—the fifth—occurred. As the foreign body was movable, the idea that it might be expelled after intubation occurred, and that if it were large enough to be arrested in the tube it could be removed with the latter.

A tube for a greater age than of seven years was easily introduced. A fit of coughing was immediately produced, during which the body—a fragment of a glass bead—was expelled, followed by mucus expectoration.

The child being quiet, the tube was removed at the end of ten minutes.

The two conditions necessary for success—mobility and moderate size of the foreign body.

The only case presenting any analogy to this, was reported to the International Medical Congress at Moscow by Bokay, upon a child, aged seven months, having some egg-shell impacted in the larynx; intubation was performed to break up the fragments, which were expelled, not through the tube, but after its removal. The method of M. Bonnus certainly deserves a trial in similar cases; it is less serious than tracheotomy, which can be performed in case of failure.—*Lancet* (London) December 11, 1897.

**QUININE BLINDNESS.**—A. W. Calhoun reports the case of a patient, a ten-year old girl from the river-bottoms of Arkansas, living in a flat section of country, upon the banks of a river, where, in consequence of the prevalence of malarial fever, the inhabitants were accustomed to use quinine freely. The patient had a chill which was diagnosed by the father as congestive, and large doses of quinine were frequently given, until, at the end of the third day, the child had taken 720 grains.

The patient becoming unconscious, the father called in the family physician, who restored her to consciousness, after several days of vigorous treatment, but she was totally blind.

In consequence of her poor health the eye was not examined until six weeks had elapsed, at which time there was a typical white atrophy of both optic nerves, the bloodvessels of the fundus were diminished to mere threads, and there was not the faintest perception of light. The pupils were widely dilated and responded to light very imperfectly. The hearing greatly affected, but much improved. Strychnine, electricity and general tonics were used for three or four weeks, but total blindness remained permanent.—*The Ophth. Record*.

**FOR INHALATION IN CATARRH OF THE UPPER AIR-PASSAGES**—Dr. Kafeman recommends as extremely effective the following combination: Menthol, 4 parts; eucalyptol,  $2\frac{1}{2}$ ; turpinol, 2; essence of pine, 1.

A few drops of this liquid are poured into a bottle, which is warmed over an alcohol flame. Balsamic vapors immediately fill the bottle, and these the patient inhales through a tube.—*Semaine Med.* WILLIAM SPENCER, M.D.

## MONTHLY RETROSPECT

### OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

---

**THE TREATMENT OF DENGUE.**—Bliem, of San Antonio, Texas, reports the results of his experience in the recent epidemic of dengue fever which spread over his State. The disease, as the writer states, bears a striking resemblance to la grippe, respiratory symptoms are absent, but the sudden onset, the high fever, the severe head, eye and bone pains, the marked prostration, the ordinarily brief duration, the coated tongue and anorexia, the dusky hue of eye and face, all are very similar. From this it is not surprising that the remedies most often needed were gelsemium, bryonia and eupatorium, with an occasional call for belladonna. Nothing seemed to beat down the temperature until it had run its course. The antipyretics had but little effect, even in reducing the fever temporarily; but they were useful where moderate anodyne effects were needed. The severest sufferings could be alleviated only by opium in some form. It was found best to relieve constipation with a laxative. Marked insomnia afflicted some patients, and for this special remedies were needed—such as caffeine, kali phosphoricum, and in the most intractable cases a hypnotic.—*Medical Century*, January 1, 1898.

**BUFO RANA IN EPILEPSY.**—According to Dewey, of Ann Arbor, epilepsy arising from fright, self-abuse or sexual excesses will often find its remedy in bufo rana. The aura preceding the attack starts from the genital organs; during coitus the patient may be seized with violent convulsions. In another form for which bufo is suitable the aura starts from the solar plexus. Previous to the attacks the patient is very irritable, often talking incoherently, and is easily angered. It is in the sexual form, that brought on by masturbation, that bufo is especially useful. It has also proved valuable in severe cases in children where the head is drawn backward in the convulsion.

Indigo has epileptic convulsions from the irritation of worms, but the patient must be low-spirited and sad—"blue as indigo"—it is "the bluest remedy in the materia medica." Bufo, like nux vomica, is vehement and irritable. These two remedies and silica and calcarea have the aura starting from the solar plexus. Stannum is another remedy for epilepsy arising from reflex irritation from worms, and also from sexual complications.—*Medical Century*, January, 1898.

**A STUDY OF STROPHANTHUS.**—As the result of a careful study of the drug, Wilcox, of New York, concludes (*Journal of the American Medical Association*, September 11, 1897):

1. The tincture of strophanthus kombe (pubescent variety) is an active and eligible preparation, of which the maximum dose should be five drops four times daily. Of the tinctures made from strophanthus hispidus, which are found in the shops, many are inert or nearly so. 2. The fluid-extracts of

strophanthus kombe (both varieties) are unsuitable preparations on account of the digestive disturbances which they occasion, and these appear to be independent of the amount of strophanthin contained in the crude drug. It is likely that the character of the preparation is responsible for these untoward effects, and possibly it may be so changed that these objections will be removed. 3. The hypodermatic tablets of strophanthin are prepared from all varieties of strophanthus, and are satisfactory preparations in doses of from 1-350 to 1-200 grain, and are not irritating to the digestive tract. The source of the glucosid and the strophanthin percentage of the crude drug are apparently without influence on their activity. The reputation which strophanthus enjoys of being an irritant drug is probably based on use of the fluid-extracts.

The advantages of approved preparations of strophanthus over digitalis are: 1. Greater rapidity of action. 2. Absence of so-called cumulative effects. 3. Non-interference with the calibre of the arteries. On the first point it can truly be said that reliance on digitalis for the emergencies which may occur in surgical cases is absolutely without a scientific basis. On the second, the fact that digitalis has ceased to be quite as harmful as it might be helpful only since the practice has become general to combine it with a nitrite, is sufficient reason for the use of strophanthus. And lastly, the marked safety of strophanthus in the aged, nephritic, gouty and atheromatous, as well as the fact that it should be the cardiac remedy for children, needs no argument for the search for reliable preparations.

THREE REMEDIES IN SPASM OF THE GLOTTIS.—Dr. Stiff, of Leipsic, Germany, was consulted by the father of a young infant of seven and a half months, who with slight signs of rhachitis from the sixth month on had suffered from very severe and persistent attacks of spasm of the glottis. Iodum 6x with calc. phos. 3x, of the first a few grains every second day twice and of the second drug the same quantity of the trit. every evening. Three days after beginning treatment there was a very violent attack, and thence on they gradually decreased in severity, so that in two months it had wholly disappeared. He cites Baehr to the effect that he prefers it to all other remedies in spasm of the glottis.

He mentions chlorine as very serviceable when *inhaled*, and quotes a case of Dr. C. Dunham, where the vapors inhaled brought about rapid relief and final recovery.

In another severe case in a child he tried iodine and kali brom. without success, finally curing the child with drosera.—*Allgemeine Homöopathische Zeitung*, Nos. 23-24, 1897.

SENECIO IN DISORDERS OF MENSTRUATION.—Fothergill (*Med. Chron.*, September, 1897) reports his personal observations with senecio in disorders of menstruation. He used a tincture of *senecio Jacobea*, 1-10; also, a 1-1 aqueous and alcoholic extract of the same plant; also a dried extract. The doses used were one to two drachms of the tincture, twenty to thirty minims of the fluid extract of the dried product. Three or four doses were given daily. He found that senecio does not cause abortion, but will cure most cases of functional amenorrhœa. In cases of anæmia, and other conditions of exhaustion due to disease, the drug was found to have little effect. It proved useful in



certain cases of dysmenorrhœa, but the relief was uncertain. In six healthy married women the administration of the drug caused the flow to appear from three to nine days before it was expected.—*The Therapist*, January 15, 1898.

**DRUG SELECTION IN THE TREATMENT OF INTRACRANIAL HÆMORRHAGE.**—Goldsbrough, of London, in the course of a thoughtful consideration of the diagnosis and treatment of brain disease, asserts that in cases of hæmorrhage localization symptoms, on account of the mechanical conditions under which they arise, become of little value as symptoms on which to select medicines. It is only the anatomical functional regions which can be mapped out as being the sphere of drug influence which are of service in this direction, say the cerebrum itself, the cerebellum or medulla, or parts of the cerebrum, the motor or sensory or speech areas. On the other hand, from the surgeon's point of view, localization symptoms are of the utmost value; no operative interference can be undertaken without them.

Then as regards the history or onset of the symptoms and their sequence. This will depend largely on the severity of the hæmorrhage, and can scarcely become of value in the selection of the remedy, except when gradual recovery is naturally taking place; then every new manifestation of power may be of value. It is this, the functional quality or character of the symptoms, to which we must look for indications for medicines, as, for example, the following: A complete palsy resulting from pressure will be left out of account, whereas a partial loss of power would be a valuable indication, showing that the damage from pressure is slight, and will probably be overcome. Symptoms of inflammatory reaction are also valuable indications, such as a moderate pyrexia, a quickened pulse, headache, vertigo, irritability of temper or mind. As regards irritative inhibition of function, if the symptoms can be separated from those of actual loss, they may be grouped along with those of inflammatory action, the actual test being the observation of returning power in any part, and the acceptance as a symptom of that phase which indicates weakness combined with irritability, as exemplified in the tendency to hyperæsthesia or perversion of sensation, and to choreiform or athetoid movements. As regards the symptoms of anæmia, which often show themselves later, they may be grouped along with those of partial restoration of function—depression of emotion, weakness of mind, and lack of mental co-ordination of what power remains being the most important. Now, if this grouping of the symptoms has any value, the following remedies will come under consideration: Arnica (in a high dilution), hypericum, belladonna, veratrum viride, gelsemium, and, later on, phosphorus, sulphur, plumbum and picric acid. One general suggestion should be borne in mind, viz., the fostering in every way of the tendency to recovery, which so often characterizes these conditions. With regard to surgery in non-traumatic cases, such can seldom be favorably considered. Dr. Goldsborough considers such aid as being available only in hæmorrhage into the substance of the cortex, on its surface or in the meninges of that region.—*Journal of the British Homœopathic Society*, January, 1898.

**THE USE OF ACONITE AND OF FERRUM PHOS. IN RESPIRATORY AFFECTIONS.**—Deschere, of New York, noting the frequency with which recommendations are made which suggest that aconite and ferrum phosphoricum are interchangeable, insists that homœopathy does not recognize any substitutes; either a remedy is positively indicated or it is not. In bronchitis, fer-

rum phos. has acted to better advantage than aconite; and the reason is obvious, for it is more thoroughly homœopathic to the prevailing conditions.

Aconite presents a dry cough, with great restlessness. The cough is short, hacking, sometimes ringing, worse after drinking water and during the night. The child often grasps at its throat while coughing, indicating local pain. The respiration is labored, anxious and quick, frequently with cough at expiration. The pulse is hard, full, and strong in inflammatory infections. This symptomatology certainly points more to an acute catarrhal or croupous laryngitis, where aconite takes first rank.

While similar conditions prevail under ferrum phos., the great similarity to bronchitis is shown in the short, dry cough accompanied by much rattling of mucus in the chest, both being aggravated during the night. The pulse is quick and full, but round, which rather corresponds to the pulse in children, especially in bronchitis, where it is rarely found to be hard and strong. The mental symptoms and fever are much like aconite. In Deschere's experience ferrum phos. has quickly checked beginning bronchitis.—*Medical Century*, February 1, 1898.

**THE COUGH OF KALI BICHROMICUM.**—According to Cowperthwaite, this drug is frequently prescribed for, and is of great value in, subacute and chronic inflammations of the lower air-passages, but is never of value in the early stages. The cough is usually dry, deep, rough, hoarse, and accompanied by a difficult, tough, stringy expectoration. Kali is often needed for the hard, deep coughs that prevail after a common cold. While the tightness and constriction of phosphorus are not present, yet there is no element of looseness in the cough itself wherein it differs from hepar sulphur. The cough is usually brought on by tickling in the trachea, or at the bifurcation of the bronchi, and, according to clinical observations, is worse after eating, when undressing, and in the morning when walking; better after getting warm in bed and when exercising. The usefulness of kali in membranous croup, with symptoms characteristic of that disease, has led to its abuse in being empirically prescribed in all forms of croup in all stages, regardless of indications. Usually it is indicated only in the later stages, and when there is little or no fever.—*N. A. Jour. of Hom.*, January, 1898.

**THE THERAPEUTICS OF CYSTITIS.**—McCurtain, of Denver, offers the following suggestions:

1. Sudden violent urging to urinate. *Petroselinum*.
2. Urine dropping from meatus instead of being ejected with force. *Hepar*.
3. High fever, restlessness, constant desire. *Aconite*.
4. Burning and pressure in the bladder. *Nux vom.*
5. Bladder largely distended. *Arsen. alb.*
6. After irritating drugs. *Camphor*.
7. Stitching, recurring, crampy pain; thick mucus and bright red mealy sediment. *Berberis aq.*
8. Urine alkaline and ropy. *Kali bi.*
9. *Natrum mur.* has greatest pain after micturition.
10. *Phos. acid.* Urine looks like milk and quickly decomposes.
11. After exposure to cold the urine deposits a slimy sediment which sticks to the vessel. *Pulsatilla*.
12. A sensation as if a ball were rolling in the bladder. *Lachesis*.

13. Sensitiveness of hypogastrium, tenesmus of bladder, burning in region of kidneys. Terebinth.

14. Retention of urine ; great thirst ; dry tongue and delirium. Hyoseyam.

15. In old people and chronic cases where the acute inflammation has subsided. Carbo veg.

16. When in consequence of long retention of urine the muscular coat of the bladder is almost paralyzed. Causticum.

17. Persistent and violent urging to urinate with great tenesmus ; urine seems like melted lead passing through the urethra. Cantharis.

18. Turbid urine and great difficulty in commencing to urinate. Chima-phila.

19. Enuresis, marked vesical irritation. Bladder sore and tender : pressure on bladder. Equisetum.

20. Irritable bladder ; dribbling of urine ; high colored, ammoniacal odor like that of horse. Benzoic acid.—*The Critique*, January 15, 1898.

PHOSPHORUS AS A COUGH REMEDY.—Cowperthwaite, of Chicago, believes that in a general way phosphorus deserves first place as a cough remedy. Its sphere of usefulness usually begins after bryonia and similar remedies would cease to be indicated, whether in an advancing catarrhal condition ending in bronchitis, laryngitis, tracheitis, or in pneumonia. Phosphorus is never indicated early, but only after product formation is fully established. In the first mentioned the cough is dry, caused by tickling in the trachea, with some mucous expectoration, and accompanied by soreness, oppression and some constriction of the chest, the latter being an important differentiating symptom. The cough is usually worse when the patient lies on the left side, worse from talking, laughing or reading, and, contrary to bryonia, is better in-doors, and worse when going from warm to cold air. In pneumonia phosphorus is indicated where there is a dry cough with bloody mucus or rust-colored expectoration, with violent oppression or tightness of the chest. It may also be useful in tuberculosis when the hollow, hacking cough is present.—*N. A. Journal of Hom.*, January, 1898.

CUPRUM IN MUSCULAR CRAMPS.—According to Kent (*Hahn. Adv.*, October, 1897), the cuprum patient is full of cramps. There are cramps in the limbs and the muscles of the chest, with trembling and weakness. In old age, and in premature old age, it is useful for those cramps that come in the calves, the soles of the feet, and the toes and fingers at night in bed. In debilitated, nervous, tremulous old people, cuprum serves a peculiar purpose. When an old man, who has been single a long time, marries, his cramps will sometimes prevent him performing the act of coition. He has cramps in the calves and soles as soon as he begins the act. Cuprum is the remedy. It is especially suitable to young men who have become prematurely old from vices, from strong drink, from late nights and various abuses, and these cramps are not unlikely to occur in such subjects. Cuprum and graphites are the two remedies for cramps coming on under these circumstances, but whereas cuprum is said to produce cramps that prevent the act, graphites is said to bring on the cramps during the act. The two remedies, however, compete closely with each other, and hence if graphites corresponds to the constitution of the patient it should be given, and the same in regard to cuprum. Sulphur also has cured this state.

F. MORTIMER LAWRENCE, M.D.



# THE HAHNEMANNIAN MONTHLY.

---

APRIL, 1898.

---

## NEURON.

BY JOHN J. TULLER, M.D., PHILADELPHIA.

(Read before the Saturday Night Microscopic Club, of Philadelphia.)

THE word Neuron signifies unit. The name was employed by Waldeyer to describe the individual cell of the nervous system in its entirety; but with the advancement of scientific investigation it became necessary to describe more minutely the individual parts of the nerve-cell or neuron, and Kölliker applied the name dendron to the protoplasmic extensions of the cell, which will be more particularly described further on (and axon to that protoplasmic prolongation which becomes afterwards the axis cylinder). It must not be forgotten that all these appendages are inseparable portions of the cell; and therefore when we speak of the neuron we speak not only of the cell itself but of the axon, the dendron, and all the collateral ramifications of these cells' appendages.

So much for the definition of the neuron. Now, where are these cells located? It has generally been supposed, by those of the profession who have not made a special study of this subject, from the fact that the current literature speaks of them always in connection with the brain, that they are confined only

to that organ; but this is a mistake. The neuron is found in every portion of the nervous system where gray matter exists—in the brain, in all the ganglia of the brain, in the spinal cord and in the sympathetic nervous system, even in the retina. Wherever is required a centre for the reception and distribution of sensory and motor impulses, the neuron will be found.

In the consideration of the neuron I will refer more particularly to the cerebral cell, because the understanding of its character and arrangements, as well as the theory of its movements and its influence over psychic phenomena, is, just at present, of the utmost importance.

It will, then, be necessary to give a description, at least to a limited degree, of its character, component parts, its position, its relation to other cells, and its function in the cerebro-spinal axis. The type of the cell, or neuron, varies in shape according to its function and location; but the general outline is more or less pyramidal. It apparently consists of a minute mass of protoplasm surrounded by a membrane, the neuraglia.

In the years previous to 1885 Golgi made a series of experiments in which he finally succeeded in establishing the fact that all true nerve-cells were provided with what he termed protoplasmic prolongations and an axis cylinder prolongation, invariably single, but frequently having many collateral ramifications. He believed that the function of the axis cylinder was to convey the nervous impulses received into and discharged from the cell; he also believed that the function of the protoplasmic prolongation was the fixation and the nourishment of the cell, because he found the minute blood-vessels distributed through the network of these protoplasmic prolongations. He believed also that the cells constantly communicated with each other by their axis cylinder prolongations and the ramifications of these prolongations. But in 1888 Ramon y Cajal, the celebrated Spanish investigator, proved beyond a doubt that these cells were independent entities; that these end filaments were free and independent of one another; that the cells in general had no communication with one another by means of their axis cylinder prolongations or their ramifications alone. This was afterwards confirmed by Kölliker, Van Gehuchten, Van Lenhæseck, Retzius and others. Ramon y Cajal went further; he found a distinct difference between the

structure of the axis cylinder and that of the protoplasmic prolongation. The axis cylinder prolongation is more regular in its outline, more uniform in its appearance, and its filaments are more evenly distributed; while the protoplasmic prolongations are irregular in size, course and distribution. Ramon y Cajal demonstrated, also, two classes of cells—the one with a long and the other with a short-axis cylinder. The former he believed to be motor, the latter sensory. But Van Gehuchten in 1891 demonstrated the actual relationship which existed between these two different characters of prolongations of the body cell, in respect to the current stimulation.

Before entering into a discussion of the theory of Van Gehuchten in regard to the transmission of stimuli to and from the cell, we must consider briefly the substances which go to make up the contents of the cell, so that the reasoning of the transmission of currents may be better understood. Under the action of the stain, methylene blue, the method of Nissl, the contents of the cell are found to present two distinctly characteristic substances. The one has sufficient solidity to take form under the action of the stain and present itself in minute irregular blocks, which are imbedded in the second a very finely-granulated substance that takes but little if any of the stain. To the former Nissl gave the name chromatic substance; to the latter achromatic substance. He advanced the opinion that the chromatic substance was that which supplied the nutrition to the cell, and that the achromatic substance was the functional substance of the cell. And this is the opinion held by Ramon y Cajal and Van Gehuchten to-day. The axis cylinder or axon is formed of the achromatic substance, while the protoplasmic prolongation consists of both the chromatic and achromatic substances, showing that the axon is composed of absolutely true nerve-tissue. In all the immediate protoplasmic prolongations it is possible to demonstrate the chromatic substance; and, indeed, this is true of the larger trunks of these prolongations. This would go to prove that the dendron, even in its ultimate ramification, is distinctly a portion of the original cell, being composed of the substance that makes up the contents of the cell.

Van Gehuchten, recognizing these facts, pushed the study of these different prolongations, that he might demonstrate the



different stimulations that passed through them; and in 1891 he brought out his theory, which was afterwards accepted by Ramon y Cajal and others.

He found, first, that the axons, no matter how dense the network, never communicated with each other; second, that no matter how dense the fibrous network, the brushlike terminations of the protoplasmic prolongations or dendrons never communicated with each other; third, that the axon always communicated with the dendron, or possibly by its terminal filament, directly with the cell. This being the case, he immediately saw that the only function of the axon was to convey an impulse away from the cell, and therefore called it cellilifugal; and the only function of the dendron being to convey the impulse toward the cell, he therefore called this extension cellilipetal.

Ramon y Cajal was the second to recognize this theory, and he described it under the head "A Theory of the Dynamic Polarizations of Nerve Elements."

I find nowhere among these authorities the theory that the axon passes directly through the body of the cell, to be distributed to the termination of the dendron. On the contrary, the investigations of Van Gehuchten and Ramon y Cajal argue strongly against this point, both agreeing that the axon is composed of the achromatic substance of the cell.

It must be remembered that a cell may have one, two, three, or even many axons, or axis cylinder prolongations, and that these axons may have many collateral ramifications, even as each cell has many protoplasmic prolongations; but the direction of the axon is always downward from the cortex, while the direction of the dendron tends invariably towards the most external layers of the cortical substance. The dendron receives its impulse in this portion of the cortical substance, and it is forced to search there for it; at the same time the axon conveying the impulse to the brain directs its course immediately to the most external portion of the cortical substance, that it may again reach by contact the terminal filaments of the dendron. The axon, in leaving the neuron in the cortical substance of the cerebrum, cannot be supposed to make one long sweep through the cerebro-spinal axis to the external surface of the body, like one long fibrous thread, to be then distributed to the

muscles; but it is acknowledged by all of the most learned investigators to pass to its special neuron in the spinal cord, and from this neuron the impulse is sent out to the external portion of the body to which it is destined. This accounts for the fact that the cellular structures of the spinal cord have a certain individual activity independent of the cortex in the brain. An impulse having been discharged from the cortical neuron would then be conveyed over the axon and distributed to the terminal filaments of the spinal dendron by the terminal filaments of the cerebral axon; and so long as this connection continued between these two terminal elements of these two cells, independent activity would be made possible in the spinal neuron by virtue of the stimulation it received from the cerebral cell without this cell being constantly taxed for stimulative supply. Thus these movements by which the body, once set in operation, continues its movements unconsciously, may be accounted for.

In regard to the theories of their action, we must understand that, as yet, they are simple theories; but under the progress of investigation the time will certainly come, and that at a not very distant day, when we shall theorize no more, but we will understand not only the grosser functions of the brain, but the finer operation of the human mind.

Weidersheim, in his study of the lower animal life, found that these independent cells had a peculiar amoeboid movement which extended to the terminal filaments of their prolongation. Duval immediately applied this action to the cells of the higher development of animal life, reasoning that, if the rule applied to the cellular structures of the lower life, it must apply to all cellular life upon the same plane of activity. He claimed that under certain influences and stimulation, these prolongations had the power of contraction and expansion; that this contraction and expansion would connect or disconnect the various cells of the nervous system, thereby setting into activity or putting them at rest. On this ground he advanced his "Histological Theory of Sleep."

I quote his words, which are as follows: "In a man who sleeps, the cerebral ramification of the central sensitive neurons are retracted, as are the pseudopodes of a leucocytes anæsthetized, under the microscope, by the absence of oxygen

and the excess of carbonic acid. Feeble excitation of the sensory nerve produces, in a man asleep, reflex reactions, which do not pass to the cells of the cerebral cortex; stronger excitations bring about an expansion of the cerebral ramifications of the sensitive neuron by following the course to the cerebral cortex, and waking is produced."

Lépine soon followed Duval in this belief, and in August, 1894, he proved the truth of this theory to his own satisfaction upon a subject of hysterical paralysis. They differed however in this, that Lépine believed that the retraction took place in the protoplasmic prolongation, while Duval held that the retraction took place in the axis cylinder. But Kölliker immediately came forward and contested the theories of both these men, saying that the terminal filaments of the axis cylinder was not contractile tissue; that the terminations were not protoplasmic but fibrous in their nature; and that transparent parts of animals, examined while living, showed no contraction or expansion of any of these prolongations under stimulation, and that this contractility belonged only to the cell. Ramon y Cajal held to the opinion of Kölliker. His investigations have, in all respects, upheld Kölliker's arguments. Pergens took two lots of fish; one he placed for forty-eight hours in the most intense darkness, while he allowed the second to remain in the ordinary light. At the expiration of forty-eight hours he killed both lots, preparing the one in the darkness, the other in the light. On examination, he found that in those which were prepared in the dark the cells were distinctly more contracted than those prepared in the light. This proves that under certain stimulation the protoplasmic body has power of contraction. This was due to the alteration in the chemical constituents of the protoplasm of the cell produced by the removal of light.

If this be true, and the theory of the protoplasmic formation of the dendron be also true, then certainly both of these elements have the power of contraction; and if they have the power of contraction, we may base much upon the theories of Duval and Lépine.

The experiment of Pergens will immediately show us why we become sleepy at night.

Thus I have endeavored to give briefly the results, on this



subject, of the investigation of the most renowned investigators of our time. And what deductions can we draw from the facts they have advanced?

Activity depends upon the contact of these prolongations. Rest depends upon their retraction or separation. Darkness produces retraction, and sleep is the natural outcome of darkness. Light alone is sufficient stimulation to re-establish activity. Harmonious contact would produce harmonious activity, the normal condition.

Normal exhaustion of the nourishment of the cell produces normal relaxation, and normal sleep follows. Sudden chemical change in the protoplasm of the cell, as would occur in shock, produces sudden contraction of the prolongation, and unconsciousness results. The administration of an anæsthetic alters temporarily the chemical constituents of the cell, and unconsciousness follows. Emotions would separate these terminations in cells weakened by the influence of heredity and other causes, and we have produced the paralysis of hysteria.

That which is true of the sensory and motor systems of cells is also true of the intellectual system. Disordered stimulation would produce mild mania. Disordered stimulation with hyperæmia would produce violent mania. Sudden and excessive irritation to the motor and sensory cells in general, as would result from uræmia, would cause disordered hyperstimulation of these structures; expansion and disordered contact and convulsions could be accounted for. Hypnotism is artificially produced hysteria; therefore, hypnotism would result from the same disturbance of stimulation as would hysteria, when artificially produced.

---

GELATINE AS A HÆMOSTATIC.—Dr. P. Carnot recommends a 5 to 10 per cent. solution of gelatine in water, or in a physiological salt solution, as a useful and a reliable hæmostatic. In epistaxis, thirty to forty c.cms. are injected into the nostril; in four patients with hæmophilia this treatment gave good results. In cutaneous wounds, a tampon dipped into gelatine and held on the wound for a few moments will cause the hæmorrhage to cease. He thinks that in many minor operations this solution may replace hæmostats. In operations on animals, as resection of the liver substance, he has seen the bleeding cease without any other measures.—*Hospitalstidende*, No. 48, 1898.

## STILLÉ AND HOMŒOPATHY.

BY CHARLES S. MACK, M.D., LA PORTE, INDIANA.

DR. CONRAD WESSELHÆFT, in his preface to his translation of Hahnemann's *Organon*, in 1875, speaking of *similia, similibus curantur*, said: "The explanations of its workings are as numerous and varied as they are unsatisfactory, from Hahnemann to the latest expounder." That Dr. Wesselhæft's statement was correct I do not doubt.\* Both by many homœopaths and by many who reject homœopathy, Hahnemann's explanation of how similars cure has been regarded as an integral part of homœopathy. Stillé† says: "It was a distorted and exaggerated perception of the principle of substitution in the cure of disease that led Hahnemann to adopt it as an exclusive dogma. . . ." Now, this theory of substitution as the correct explanation of how similars cure must be gotten rid of: so long as it clings to one's mind, that person is unable to accept the truth that the cure of which *similia* is the law transcends the possibilities of rational practice, for practice based upon the theory of substitution is a part of rational medicine.‡

It being agreed, then, that the cure of which *similia* is the law is not, as Hahnemann supposed, the substitution of a drug's pathogenetic effects for disease, and subsequent recovery from drug effects, one does well to persistently inquire (until he receives a satisfactory answer), What is that particular cure of which *similia* is the law? The answer I offer is that that particular cure is *such modification of the quality of vital processes and their effects that, whereas these processes and effects are abnormal, they shall become normal (or approximately so) as the immediate (i.e., not secondary) effect of the medicine used.* This definition helps to make clear, I think, a position which the homœopath may forever occupy and be invulnerable. In no rational practice is it possible to attempt this "immediate" cure, for to any

\* For a theory recently offered see, in the HAHNEMANNIAN MONTHLY for December, 1897, a paper entitled "The Modus Operandi of Dynamic Drugs: a Theory submitted by one who reads Swedenborg."

† *Therapeutics and Materia Medica*, Fourth Edition, vol. i., p. 256.

‡ See, in the HAHNEMANNIAN MONTHLY for July, 1897, a paper entitled "Hahnemann's Erroneous Explanation of Cure."

given rational practice the data must be in themselves knowable. As vital processes are not *in themselves* knowable (they can be known only *in their effects*), this cure transcends the possibilities of rational practice: it can be intelligently attempted only under guidance of a law of nature stating what relation between disease *as known in effects* and a dynamic drug *as known in its immediate effects upon normal vital processes* marks that drug as capable of effecting an immediate transformation from abnormal to normal (or approximately normal) of vital processes and (in consequence) their effects. That this particular cure transcends the possibilities of rational medicine is good and sufficient reason why those who believe in this cure, and in *similia* as the law of it, should identify themselves by name with homœopathy, that they may be distinguished from those who regard rational practice as the *ne plus ultra* in medicine. As this particular cure is entirely different from any that can be attempted in rational practice, or intelligently attempted in empiricism, it, in the light of definition, becomes evident that one can consistently accept homœopathy, and at the same time accept rational practice and empiricism. I am confident that at some future time all discussion of homœopathy will be preceded by accurate definition of that particular cure of which *similia* is the law, and I believe that for lack of such definition much energy has been misspent, both by advocates of, and opponents of, homœopathy in past controversies over the subject. I think that, using the definition above given, I showed in the October, 1897, number of the *American Medical Monthly* (Baltimore) that neither Brunton nor H. C. Wood understands even of what cure *similia* purports to be the law, and, in the *HAHNEMANNIAN MONTHLY* for February, 1898, that Headland, in his famous work on the *Action of Medicines*, betrayed ignorance of what is that cure. I think, too, that in my little book, *Principles of Medicine*,\* I have used to advantage accurate definition of the cure undertaken in any given practice of homœopathy, and accurate definitions of rational practice and of empiricism. I feel, to say the least, very hopeful that such definitions will prove useful in disentangling the snarl in which these subjects now are.

Stillé, before he has completed a full page of the introduction

---

\* Published by the W. T. Keener Co., 96 Washington St., Chicago.



to his work above-named, says: "With scarcely an exception, substances which, in a certain dose, are capable of destroying life, are also, in a certain less amount, adequate to save life." Good! He continues: "Their deleterious action is only an excess of their salutary action; and, generally, the former is proportioned to the latter." So far as concerns the use of dynamic drugs in rational practice for the sake of their pathogenetic effects upon man, it is true that any salutary action immediately (*i.e.*, not secondarily) resulting from their use is, in kind, the same as the deleterious action of larger doses. But right here we would fix attention upon the fact that the salutary action sought in any given practice of homœopathy is distinctly *not* the same in kind as the deleterious action of larger doses, but is an immediate transformation from abnormal to normal (or approximately normal) of vital processes and (in consequence) their effects. See the above definition of that cure of which *similia* is the law. This point is so important that I would not only fix attention upon it, but would rivet it there until the point is thoroughly understood. When one gives morphine as an anodyne, atropine as a mydriatic, ergot as a contractor of vessels, strychnine as an excitant—when, in short, he in rational practice uses any drug for the sake of its pathogenetic effect upon the patient, the action he sets up is *in kind* the same as the deleterious action of that drug in fatal or serious poisoning; but what he attempts with any one of these, or other dynamic poisons, as a homœopathic remedy, is to immediately transform from abnormal to normal (or approximately normal) vital processes, and to do this is to set up an action distinctly *not* the same in kind as the deleterious action of the drug in larger doses. Stillé continues: "In this, medicines obey a general law under which every capacity for good is equally a capacity for evil. Light and heat, the vivifiers of the universe, would become the most powerful agents in its destruction were their operation uninterrupted and intense." That there is "a general law under which every capacity for good is equally a capacity for evil" is true, but under that law there are sub-laws—subdivisions, and to speak as if dynamic poisons fell in the same subdivision as do light and heat is a most serious error; it is, practically, an error which has for centuries led astray medical thought and medical practice. Under the

same subdivision as falls harm from excess of heat or from excess of light, falls harm from excess of food eaten or from excess of water drunk; but under an entirely different subdivision falls the effect of a dynamic poison as a homœopathic remedy. Under the general law stated by Stillé is a sub-law or subdivision known to readers of Swedenborg as *the law of evil uses*, and under this subdivision falls the use of dynamic poisons as homœopathic remedies. Failure to recognize under the general law stated by Stillé (viz., "every capacity for good is equally a capacity for evil") two subdivisions, under one of which fall the use and abuse of agents which in moderation are hygienic, and under the other of which fall the harm and the use of agents which are essentially evil and never hygienic—failure, I say, to recognize these two subdivisions has led astray not only Stillé, but, through centuries, multitudes of practitioners in the wake of thinkers and writers upon medicine; and, through all future ages, the man who fails to recognize these two subdivisions under the general law will, of necessity, fail to understand the philosophy of homœopathy;—a most useful practitioner of homœopathy he may be, but the philosophy of homœopathy he will not understand. I cannot too earnestly urge every reader of this paper to consider the significance of these subdivisions: the matter is treated of in my little book, *Philosophy in Homœopathy*.\* If one wishes to aid in the extinction of the present *odium medicum*, and in a more widely-spread recognition of homœopathy, and wishes to consistently advocate homœopathy while advocating and practising rational medicine and empiricism, let him accurately define that cure of which *similia* is the law, and familiarize himself with the philosophy of homœopathy.

---

TREATMENT OF FACE PRESENTATIONS WITH THE CHIN POSTERIOR.—Dr. Volland recommends the introduction of the whole hand over the face so that the index finger remains under the chin, and the rotation of the same as far as possible between the pains, so that the chin gradually comes to lie more at the side. During a pain the head is held fast in its new position and rotated again in the following interval.

---

\* Published by Gross & Delbridge, cor. Wabash Ave. and Washington St., Chicago.

## SUGGESTIONS ON THE BACTERIOLOGY OF TYPHOID FEVER.

BY JOSEPH C. GUERNSEY, A.M., M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia, February, 1898.)

YOUR Bureau on *Materia Medica* begs leave to submit "Typhoid Fever" as its subject for report this year. We recognize the fact that the consideration of our chosen topic belongs to the realm of clinical medicine; but the special interest typhoid fever is exciting just now has induced us to present this disease, and to invite a full discussion of its cause and treatment.

In the Annual Report of the Board of Health of this city we find that during the year 1897 there were 2994 cases of typhoid fever reported, an increase of 505 cases over the year 1896. This showing is grievous and wholly unpardonable, because typhoid fever is a preventable disease!

Of typhoid fever *we know* these things: 1st. It is of germ origin; 2d. It is highly communicable; 3d. It can be largely, if not wholly, prevented by the filtering of the germs from drinking-water, and still more effectually by killing them by boiling the water. As a large majority of our fellow-citizens are either ignorant of the necessity of boiling their drinking-water or are too careless to do so, it becomes our duty as hygienists and conservers of the public health to insist upon its filtration. In a recent work of high authority on pathology the author naively remarks of typhoid fever: "In Philadelphia . . . the disease has gradually assumed an endemic character, and we now have typhoid patients on our visiting-lists during every month in the year." This sentence might be amended to read with perfect truth as follows: "In Philadelphia, owing to the persistent, insistent and consistent contamination of its entire water-supply by the factories, privies, sewage-drains, cess-pools and cemeteries located on the banks of its rivers and polluting its water, typhoid fever has gradually assumed an endemic character," etc. Why, of course it has, and what else could you expect? Now, suppose the water had been carefully and honestly filtered before it was supplied to the citizens of Philadelphia? Well, in that case we would have the best of



reasons for expecting a report like the following, which gives the statistics of typhoid fever at Girard College before and after the introduction of a filtration-plant which filtered all the water used in the institution. The filter was put in towards the end of the year 1893, and immediately there was a marked decrease in the cases of typhoid fever:

Year.	No. Cases.	Deaths.
1890, . . . . .	24	3
1891, . . . . .	49	2
1892, . . . . .	19	1
1893, . . . . .	16	1
Total, . . . . .	108	7

FILTER.		
Year.	No. Cases.	Deaths.
1894, . . . . .	9	0
1895, . . . . .	5	0
1896, . . . . .	4	0
1897, . . . . .	8	0
Total, . . . . .	26 (all light cases.)	0

We can safely assume that out of these twenty-six (light) cases, some of the patients contracted the fever by drinking unfiltered water while visiting outside of the institution.

The experience of Girard College is by no means an isolated example of the beneficent results of filtered water. There are innumerable instances of other large institutions whose drinking-water has been honestly filtered that show similarly good results. I only give these figures to prove what wholesome drinking-water can and does accomplish in freeing mankind from the blighting effects of dire disease.

With these facts known, why, in the name of all justice, mercy and charity, our city fathers have for so many years failed, and still do fail, to provide pure water for the people who pay taxes for this very purpose, is beyond my knowledge. They might just as well refuse to provide the means to put out the fire when our houses are burning up, or decline to afford us police protection, for both of which services we pay only a moderate tax, and yet receive ample return, as not to give us the pure water we pay for, and are willing to pay still more for by an appropriation from the Special Loan.

In these days of enlightenment, their failure to furnish us with wholesome drinking-water is not due to ignorance.

Water, however, is not the only fluid in which typhoid germs live, move, multiply and infect. Milk, that great staple of food which comes upon our tables looking so white, so pure and so innocent, is full of deadly peril, for often it is loaded with the dreaded bacilli of typhoid, tuberculosis, diphtheria, and what not. I cannot take up the milk question to-night, or even briefly refer to the many sources of its contamination. I can only say that milk is not wholly safe unless sterilized. But impure water and milk are not the only sources of typhoid germs. Sometimes they spring from freshly upturned earth, as witness the increase in cases of the fever when the trolley rails were being laid a few years ago, and nearly all the streets of our city were torn up. Epidemics occur in new sections of a city where foundations are being laid for rows of new houses. Defective plumbing also adds to the list of victims.

The bacteriology of typhoid fever is of vast importance, and I now beg to submit for your consideration the fact that the true typhoid bacillus is found in the urine, instead of the fæces! The data for this suggestion, taken largely from Braithwaite's *Retrospect*, January, 1896, are to this effect: 1st. If the typhoid bacilli are in the urine of patients suffering from typhoid fever, and are generally absent from the fæces, it is the urine, and not the fæces, which spreads typhoid infection. 2d. If typhoid bacilli are constantly present in the urine of typhoid patients, the fever may be diagnosed by a bacteriological examination of the urine. The theory currently held and acted upon is that typhoid fever is an "intoxication process," that the typhoid bacillus vegetates in the intestine, that it effects a lodgment in the intestinal walls, and that the poisons which are elaborated by the bacilli are absorbed into the system from the intestine. It is true that a bacillus (*bacillus coli communis*) is found in large quantities in the stools of typhoid fever patients. But this *coli communis bacillus* is not the true typhoid bacillus.

Here are the results of Wathelet's careful examination: Out of twelve cases of typhoid fever, the true typhoid fever bacillus was detected in the stools of only four; and in these four cases the typhoid fever bacillus was detected only four times in a total of twenty-four examinations. In the other eight cases of typhoid fever the typhoid bacillus appeared to be absent from the stools throughout the whole course of the disease. As actual observations seem to point to the absence of typhoid fever

bacilli from the intestinal tract, we are forced to a new theory of typhoid fever—that of blood infection. Many arguments are advanced in support of this theory, one of the most interesting of which is that the eruption of pink spots on the skin of the abdomen, chest, etc., is due to lodgments of the bacteria in the capillaries. This interpretation of the skin eruptions in typhoid fever is confirmed by the fact that the specific bacteria have been cultivated from these pink spots. The inflammation of the Peyer's patches may be owing to a lodgment of typhoid bacilli in the adenoid tissue, similar to that which occurs in the capillaries of the skin; while the occasional presence of typhoid fever bacilli in the intestine is probably due to a certain number of them getting through the intestinal wall.

The authors of the article from which I have been quoting state that in six out of seven cases of typhoid fever examined by themselves the true typhoid bacilli were easily detected in the urine. In some cases, even before incubation, the urine is absolutely turbid with typhoid bacilli.

The above is a very meagre and a very incomplete statement, *a*, of the theory of typhoid fever being due to blood infection, and, *b*, of the urine being the source of infection rather than the fæces.

Bearing the above facts in mind, we arrive at two conclusions: 1st. Bacteriological examinations of the urine should be made to determine the diagnosis in doubtful cases when typhoid fever is suspected. 2d. The old teaching of the necessity of disinfecting the fæces alone, while the urine of typhoid fever goes unwhipt of justice, can rank only "as a mere counsel of perfection;" and the most positive orders must hereafter be given to disinfect the urine also. The urine is more dangerous as a source of infection than the fæces, because, while constipation is more or less present during the fever, the urine flows all the time, sometimes involuntarily, soaking the sheets and mattresses, thus rendering them a source of infection that lasts no one can tell for how long.

In accordance with the foregoing data, I have for the last two years, in my typhoid cases, ordered the urine to be rigidly disinfected, as well as the fæces. And in my lectures to the nurses in the training-school of the Hahnemann Hospital I have taught that this must be done.



## THE TECHNIQUE IN THIRTY VAGINAL HYSTERECTOMIES.

BY DE WITT G. WILCOX, M.D., BUFFALO, N. Y.

Visiting Surgeon to the Erie County and Homœopathic Hospitals, Surgeon-in-Charge Lexington Heights Hospital.

As there yet seems to be some difference of opinion both in Europe and America as to the technique of vaginal hysterectomy, it may not be out of place for each operator to contribute his statistics, together with the *modus operandi*. My paper, therefore, is merely a contribution to that end. I have endeavored to be somewhat minute in my detailing of method for the following reason: In observing various surgeons operate I frequently see a minor, or possibly it may be a major, detail that is entirely original with the operator, and which in itself vastly facilitates the operation, yet, were he writing a description of the method, he would regard the procedure so trifling that no mention of it would be made. It is in the observation of such details that in the aggregate mark the rapid from the slow, the neat from the untidy, and the precise from the fussy operator.

You will observe, from the table set forth, there are recorded thirty vaginal hysterectomies. The braided-silk ligatures were employed in twenty-eight; the remaining two called for the clamp; owing to the shortness of the broad ligaments. In all cases I stitched the central portion of the vaginal vault, and brought the silk ligatures through the corners and introduced a gauze drainage into the same. There was no primary death due to the operation, up to the twenty-first case. One case died two weeks afterward, wherein the autopsy showed fibrous heart-clot. There have been two deaths due to operation since that time.

I have not observed any striking symptoms following the operation. Some patients have had flashes of heat, nervousness and general restlessness incident to the artificial menopause. I have observed no change in the sexual status of the patient. None have developed mental disturbance, and in five a condition bordering upon mania has been overcome. In two cases of cancer involving the vaginal wall I opened into the bladder.

One patient continued having urinary discharge through the vagina until her death, some six weeks after, due to rapid spreading of the disease. In the other, the bladder was sutured and healed save a small fistula, which in time closed. One patient died eighteen months after operation, from return of cancer.

I remove ovaries and tubes when it is possible to do so without unduly prolonging the operation, although if not diseased I see no harm in leaving them.

The technique of operating in the last twenty cases was as follows: The earlier operations were essentially the same, differing only in minor points. The method employed was the same in general for all cases up to a certain point, no matter what the cause. Two days previous, if possible, the bowels are well emptied by mild cathartics. On the morning of the operation (the operating hour being 2 P.M.) the parts are shaved, thoroughly scrubbed, bichloride vaginal douche, and a final enema. There being no contrary indications, I prefer chloroform to ether.

Patient is placed on a plain metallic table with a glass top, which I regard as better than the many complicated structures now in use. A small Kelly pad is placed under the hips, which are projected sufficiently over the edge of the table to allow the perineal retractor to be used with freedom. A little point in reference to the position of the thighs is worth considering. If the legs are supported in slings or upon crutches so that the thighs are at right angles to the body, the pelvic viscera does not descend so low in the pelvis, and for that reason is not as accessible as when the thighs are pushed well down upon the body.

A pain in the "belly" or pelvis induces a patient instinctively to draw the thighs as closely to the body as possible, either by bending the body over to the thighs or bringing the thighs to the body, for the evident reason of relaxing every muscle and ligament. In operating upon pelvic organs through the vagina we seek to accomplish the same thing, namely, relax every support, and thus bring the uterus as low down as possible. I have seen a number of cases where it was almost impossible to draw the uterus sufficiently forward to make an operation when the thighs were but half flexed, which when fully flexed rendered the uterus unusually accessible.

To accomplish this desideratum, it is essential that an assistant hold each leg. There is no crutch that will do it thoroughly. A sling around each knee, when the leg is flexed on the thigh, together with a band passing under one shoulder and around the neck, will lessen the burden of the assistants, but will not accomplish the object alone.

A few words as to the arrangement of the assistants. To so place the latter that they can most effectively assist and yet not obscure the field of operation to the witnesses who may be closely clustered about the operator, is quite necessary. An assistant at each side of the patient, facing the operator, can hold the respective leg on his side and have one hand free to assist the operator. An assistant seated to the operator's left can hold the guy ropes, perineal retractors, and such other aid as may be required. Another assistant at his right should have either at his side or upon his knees a large tray containing all instruments required, and at his side a low table with ligatures, etc. In this manner the least space is occupied and the field the least obscured for witnesses.

A nurse standing just at the side of the right-leg holder can manipulate the douche, and one standing similarly on the left can hand sponge-pads, although I regard the douche ample for clearing the field. The Fritch douching speculum or retractor is excellent for this purpose, and saves all sponging.

Now comes the last scrubbing act. Douche, green soap, ether. I then seize the anterior lip of cervix with a Skene's tenaculum forcep, draw it down, and with a Martin needle and holder (usually Russian) I introduce the traction or guy rope. This is a No. 12 braided-silk ligature. It is passed through both anterior and posterior lips, and then hooked out from between the lips so as to make a guy for each lip of about six inches long. It is quite desirable to have these of the same length so that both may be held in one hand, hooked on forefinger and thumb. Just here I have found quite a useful procedure, namely: traction upon the ligatures and a massage-like movement on both broad ligaments from within the vagina. It is surprising to find to what degree an otherwise fixed uterus will descend when thus manipulated.

In virgins and women who have extremely long vaginae with shortened broad ligaments it becomes a difficult matter to make



a skilful hysterectomy unless the uterus can be made to descend. Five minutes spent in this manipulation, when it is required, is time well occupied.

Slipping the guy ropes onto the thumb and forefinger of my left hand, I elevate the cervix as much as possible, and with a pair of sharp-pointed, flat-curved scissors I cut through the posterior vagino-cervical juncture. The objection raised by German surgeons to this part of the work that it causes unnecessary bleeding, and that the cautery is better, seems to me foolish, because of the very slight bleeding on the one hand, and the disagreeable effects of the cautery on the other, as well as the increased time consumed by the cautery.

It is a matter of a few seconds to cut through this tissue, push the finger along the posterior wall of the uterus, separate it from the rectum, and push on through the pelvic peritonæum. A sponge-compress pushed up into this opening will effectually stop all hæmorrhage, but precaution will suggest a clamp attached to the compress, to obviate its being left in the pelvis.

Now depress the left hand, holding the guy ropes, and use the scissors similarly on the anterior vagino-cervical junction. But little difficulty is encountered in separating the bladder and uterus, unless there has been a long-standing or unusually severe pelvic inflammation, with consequent adhesions. A compress in this opening will also control the bleeding. The uterus is now pulled forcibly to the operator's left, and the lateral vagino-cervical tissue is severed up as far as one would expect to find the uterine artery. This depth can only be governed by experience, but the higher one can go into the broad ligament without hæmorrhage, the less bulky and less numerous will be the ligatures employed.

At this juncture I have the left assistant take the guy ropes, making outward and lateral traction, while with thumb and finger of the left hand I seize about one-half of the lower portion of the broad ligament. With a Dechamps or ordinary transfixion-needle in my right hand I pass a braided-silk ligature (about No. 8 or 10) through the broad ligament close to the uterus, unless there be special reason why it should be any distance from that body. This is tied tightly, left long. (I have tried the "loops" for untying the ligatures, and find they re-

quire too much time to adjust, and, if drawn upon accidentally, will loosen the ligature prematurely.)

This portion of the broad ligament is now severed close to the body of the uterus. The other side is treated similarly, having the right-hand assistant take the guy ropes, using my right thumb and finger to seize the broad ligament, and my left hand for the needle (being ambidextrous). The severing of this half of the ligament will allow the uterus to descend to quite a distance, enabling me to encircle the balance of the uterine support, including the round ligament, the tube, and ovarian artery.

It is at this point that the question of removing the adnexa must be settled. The finger passed along the upper border of the ligament will find the tube and ovary, which, if not affected, can readily be brought down and included with the uterus on the distal side of the ligature. There is no special necessity of hugging close to the uterus at its fundus when applying this ligature. After the ligament is entirely severed on one side, the uterus can be everted, and now is without the vagina, simply hanging by the remaining half of one ligament, which is encircled, including tube and ovary, and severed.

The conduct now consists of thorough douching, controlling all bleeding points of any size (few will be found if the four ligatures are properly applied), filling the bladder to ascertain its integrity, and, lastly, stitching the vaginal vault. To do this well, I pull down the pelvic peritonæum in front with long forceps, and with another pair seize the vaginal mucous membrane immediately in front of this. These I give to an assistant, and then draw down the pelvic peritonæum and vaginal membrane posteriorly in the same manner. Through all I pass a chromicized, catgut suture, No. 2, with a Martin needle, in a holder. I sew up the vaginal vault sufficiently to leave a small "corner," through which emerge the silk ligatures, and into which I pass a narrow strip of iodoform gauze for drainage. A T bandage, evacuation of the bladder, and the operation is finished.

I do not mean to say that I make no deviations from the foregoing method, but in simple cases I scarcely make a different move. If I am not drawing my paper out too long, I will now compare the method with others in vogue.

First, as to the time. The greatest length of time required was one hour and forty minutes (one of my first cases), the least time twelve minutes. When I compute time I mean from the moment I make the incision into the cervical tissue until the vault is stitched up and the drainage placed. In the case where twelve minutes was consumed the patient was upon the operating-table but twenty-five minutes. I should estimate my average time was thirty-five minutes, which, so far as I can learn, is not more than the time required by other methods.

Beginning again with the starting-point, let us compare, first, the use of the cautery with the scissors. The former, it is true, avoids bleeding, which is all that can be said in its favor. It is clumsy, it is not "elegant" (and why make an operation barbarous when unnecessary?), slower and less accurate. No man can handle a long-handled cautery with the precision and dexterity with which he uses the scissors. The odor and smoke of burning flesh is anything but agreeable, even in the operating-room. The little bleeding occasioned by the scissors is so quickly controlled, if the operator is rapid, that the blood lost need not be considered. Certainly the sight of blood is not as offensive to the eye as is the smell of burning flesh to the nose, if we are not considering the patient in the matter.

The after-treatment is simple, as nature has so little repair work to accomplish. Until the stomach is controlled, I give no nourishment or drinks. If this lasts longer than twenty-four hours I give small quantities of champagne or grape-juice. I endeavor to obtain a bowel movement at the expiration of forty-eight hours, at which time the vaginal tampon is removed—not, however, until after the movement, as the tampon aids as a support if there be any straining. The gauze drainage is withdrawn on the third day, when a vaginal douche is given.

The shock is so slight that many patients believe they can walk about in four days, if allowed to do so. The patient is catheterized for three or four days, and then allowed to void urine herself if she can do so without straining. The less catheterism is employed the better. Two weeks' rest in bed is the average time required. The removal of the ligatures is, perhaps, the only drawback the operation possesses. Occasion-



ally they come away of themselves with the douching, but more generally they require considerable "coaxing," or, if the patient must leave my care before they have come away, I place her upon the table and remove them with the scissors.

Another comparison I should like to make is: this method with that of dividing the uterus into halves. In simple cases not attended with large fibroids, I fail to see the advantage in its employment. The same ligation must take place, the same dissecting of the vagino-cervical union, plus the time of dividing the uterus. There is a risk of injuring bladder, intestines and rectum. It is not more rapid, it is not less dangerous, nor is there less shock. Certainly it is not only wise but absolutely necessary to resort to some such section where the uterus or attending tumor is too large to pass through the vaginal canal.

A few words regarding the method of ligation. My first operations induced me to use the clamps for the broad ligaments. I have discarded them entirely, as the method is clumsy, not aseptic, painful, and a source of future injury to the parts. It may be a trifle quicker to slip on to the ligament a long clamp and cut it (the ligament) free from the uterus in two or three bold strokes of the scissors; but how unworkmanlike. It seems like an acknowledgment that one cannot ligate the uterine or ovarian artery because one is not just sure where they are. Hence he will be on the safe side, and squeeze an entire ligament into the jaws of a steel trap, and allow that to remain dangling from the patient for ten days or more.

The material for ligating these structures comes up for consideration. A sufficiently large catgut becomes too bulky to tie tightly; besides, its sterility is always an open question. A medium size, even if well chromicized, cannot be depended upon to outlast the possibility of secondary hæmorrhage. I frequently tie the upper portion of the ligament (including the ovarian artery) with catgut, particularly if the amount of tissue included is small; but for the uterine artery, with the lower portion of the ligament, I invariably employ braided silk, about No. 8, or possibly a little smaller. The proof of the satisfaction of this manner of ligation lies in the fact that I have not had a single case of secondary hæmorrhage,

or, in fact, scarcely any hæmorrhage after the patient left the table.

Some years ago a method was devised and employed of peeling the uterus out from its "nest" in the pelvic tissue without clamp or ligature. So can you amputate a man's leg without ligature or clamp, but the chances of his bleeding to death are somewhat greater than where you ligate the bloodvessels. There are bloodvessels passing into the uterus, and if you remove the uterus from the body you must, of necessity, sever these bloodvessels in some form. You may, of course, tear them off in such a way as to facilitate their retracting and the blood coagulating, but the chances are nine to one there will be hæmorrhage. The question comes home with some force when I ask myself: "Would I be willing that my wife should undergo this operation at the hands of a man who persisted in operating by this method just to show what could be done successfully in rarely fortunate instances?"

The length of time that the ligatures should remain is best settled by circumstances; certainly they should remain not less than ten days, and two weeks is better. If they do not then come away with some traction, there is no harm in leaving them for some weeks. If my patient is not to leave town after her operation, I not infrequently have her return to the hospital in a month's time, and then dissect out the ligatures, if they have not already come away by the daily douches which I have my patient take until all irritation has disappeared. If she is to leave the city upon her departure from the hospital, I remove them before she goes. If the stump which the ligature encircles has been brought down into the vagina—and this should be done especially with the lower segment of each ligament—then it is best to snip off the stump with the ligature and take all away. I do not cauterize the remaining surface, as I deem it unnecessary, and the doing of it either gives the patient pain or requires her taking an anæsthetic.

I shall not go into the results of this operation, as my paper takes up the technique only; but suffice it to say that by the method herein outlined the results have been most gratifying in the thirty cases so far operated upon.

THE SURGICAL TREATMENT OF THE IRREDUCIBLE FORM OF  
UTERINE ANTEFLEXION.

BY B. F. BETTS, M.D., PHILADELPHIA.

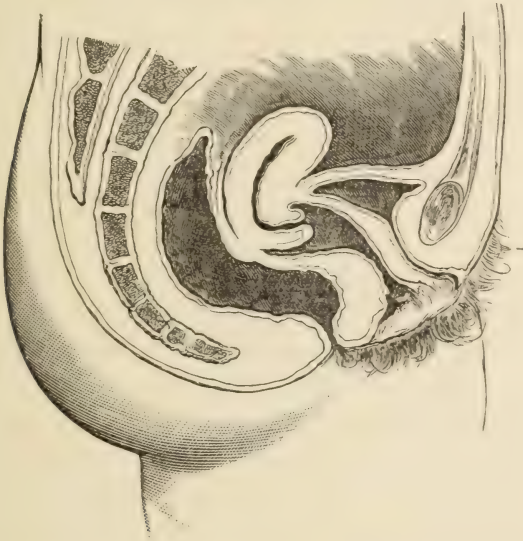
(Read before the Homœopathic Medical Society of the State of Pennsylvania, Scranton, 1897.)

THE uniformity with which one variety of uterine ante flexion recurs, despite our best directed efforts to effect a permanent replacement by other than surgical methods, has suggested the propriety of designating it "The Irreducible Form of Uterine Ante flexion." As this variety, if not surgically treated, uniformly tends to the development of serious pelvic symptoms, accompanied by dysmenorrhœa and such an impairment of the procreative function as to cause sterility, I have deemed it worthy of the consideration of this Society, with the hope that it may lead to an early recognition of the condition in the future, in order that suitable surgical measures may be instituted for the relief of such patients before permanent structural lesions develop. It is in the domain of preventive treatment that gynæcology needs most the services of the general practitioner, for it is to neglect upon the part of the patient or her physician that we must assign the necessity for the formidable mutilation so often effected, at the present time, to secure curative results. The condition under consideration is most frequently met with in young women in whom the uterus is prolapsed to the first degree, so that the cervical extremity rests upon the floor of the pelvis, to be influenced by fecal accumulations within the rectum, which tend to deflect it towards the vaginal outlet until the bent posterior wall of the cervix becomes permanently hypertrophied and elongated. In the anterior portion of the cervical wall atrophy is effected from lack of blood supply at the point of flexion. The hypertrophy of the posterior wall and the atrophy at the point of flexion anteriorly are characteristic features of the irreducible form of uterine ante flexion. In some cases the ante flexion is due to an imperfect development of the entire reproductive system at the time of puberty. The fundus remains small in proportion to the cervix, as it is during childhood, and the anterior vaginal wall with the utero-vesical ligaments are so shortened as to



tether the cervical portion anteriorly whilst the more perfect circumferential development of the bony pelvis is being effected. Intra-abdominal pressure, directed against the fundal portion of the uterus, from constricting bands about the waist, keeps the cervical portion under more or less constant irritation. Under such circumstances the posterior wall of the cervix and the posterior uterine ligaments (the utero-sacral supports) become permanently thickened by inflammatory deposits, so that the organ is then held firmly in its abnormal position and a perfect replacement of the prolapsed and antelexed uterus becomes

FIG. 1.



Irreducible antelexion of the cervix from prolapsus with hypertrophy of the posterior lip near the vaginal intersection and atrophy of the corresponding part of the anterior lip and inflammatory thickening of the utero-sacral ligament.

comes impossible. These conditions are now readily distinguished from the reducible form of antelexion, which is favorably influenced by the use of the ordinary pessary without surgical treatment. The flexion in the irreducible variety is not always at the junction of the body with the cervical portion near the internal os, but it is most frequently at a lower point in the cervix, even midway between the external and internal os, or at the middle third of the cervix—differing in this respect from the reducible form, in which the flexion is at the neck of the organ at the internal os. At the point of flexion in the

irreducible form we detect a sulcus or depression in the anterior wall of the cervix underneath the vaginal mucous membrane, when firm pressure is directed against it. This cleft in such cases cannot be obliterated in the effort to straighten the long axis of the uterus because of the thickened condition of the posterior cervical wall. In aggravated cases the fundus may become retroverted whilst the cervix remains anteflexed, and conjoined with this the prolapsus may be even more marked than at first (Fig. 1).

With the most severe form of displacement the tubes and ovaries become involved in the general disarrangement of the pelvic viscera. Under such circumstances there is imperfect uterine drainage. At the time of cervical dilatation and curettage of the uterus I have frequently been able to demonstrate the presence of a marked stricture at the point of flexion, and beyond this a depression in the posterior wall of the uterus and most dependent part of the uterine cavity. In this depression a pool of mucus and menstrual debris is found which only awaits septic infection to become the source of endometritis, with subsequent fallopian salpingitis and ovaritis. To painful menstruation we then have added menstrual irregularities, persistent backache, pelvic tenesmus and chronic invalidism. As constipation continues, hepatic torpor develops, with its consequent malassimilation and subsequent anæmia. Constipation thus plays an important rôle, both in the development and subsequent history of the conditions under consideration.

The treatment of this form of anteflexion has been by—

1st. The use of pessaries.

2d. The uterine stem.

3d. Bilateral discission of the cervix.

4th. Posterior discission (Sims' operation).

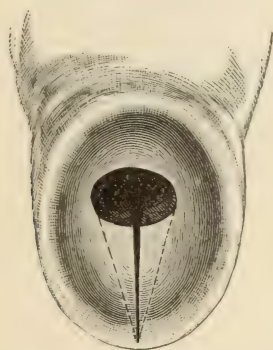
5th. Gradual dilatation (tents; small divulsors).

6th. Forceful dilatation (Goodell's large divulsors).

All these methods have failed, excepting those of Sims and Goodell. In married women, Goodell's method has effected favorable results when it removed the barrier to impregnation; otherwise the dilatation has soon been followed by contraction. As salpingitis and ovaritis are frequent accompaniments, impregnation only occurs in rare instances; hence the method is limited in its usefulness. Even when impregnation does occur

after dilatation, the cervix is liable to serious laceration at parturition, because of the thickened condition of the posterior wall against which the presenting part of the child impinges with such force as to sever it from its attachment to the weaker structure in the anterior portion of the cervix. Sims' posterior discission of the cervix is the most effectual treatment for the irreducible form, but it is open to the objections that it either leaves a weak point in the cervix, which readily develops into a serious laceration at parturition, or the incision becomes obliterated by nature's efforts at repair within a few months after the operation has been performed. The operation devised by Prof. Dudley, of Chicago, overcomes these objections, and when modified by a slight additional operation upon

FIG. 2.



Os uteri dilated after curettement. The posterior lip incised; the dotted lines indicate area to be denuded. (Dudley.)

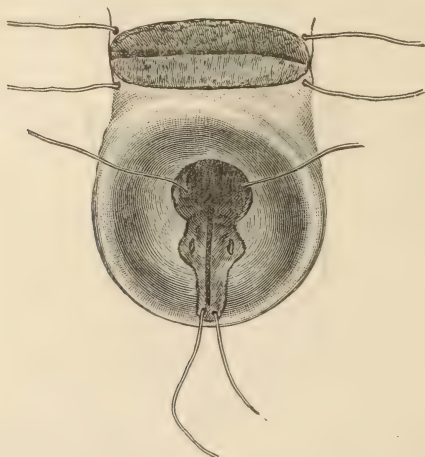
the anterior vaginal wall in front of the flexion, so as to strengthen the wall at this point, leaves nothing to be desired.

The patient is prepared for the operation with the usual antiseptic precautions; she is etherized and placed in the lithotomy position. The cervix is carefully dilated, by means of Prof. Pratt's cervical dilators, which I have modified by the addition of a groove or channel upon the opposite sides of each instrument, in order to facilitate the discharge of the pent-up uterine secretions when the instrument is being pressed firmly into the cervix, so that its piston-like action may not force these secretions through the uterine cornua into the fallopian tubes. The uterus is next curetted and washed out with a bichloride solution, 1 to 4000, and after that with plain water. Kuchen-



meister's scissors are used to cut directly through the posterior wall of the cervix up to the point of flexion, that is, through the point of internal stenosis and back to the junction of the vaginal wall with the cervix. A sound is next passed, to ascertain whether or not the cavity of the uterus forms a straight line with the cervical incision, so that good drainage may be secured. If there be still some stenosis, the incision is deepened from within upward by the use of the knife. The projecting knuckle anteriorly at the point of flexion in the canal of the cervix is also cut through until the uterine outlet is straight and patulous. The ears or flaps on each side of the incision are trimmed up and

FIG. 3.

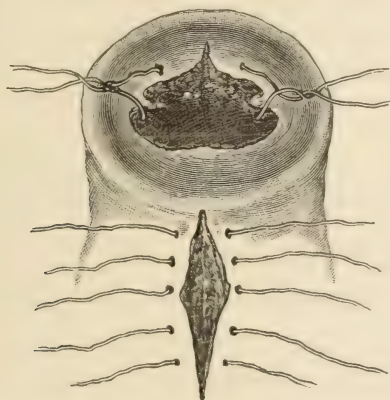


Wedge-shaped piece of tissue removed from anterior vaginal wall at point of cervical flexion. (Skene.) Sutures introduced.

the mucous surfaces along the vaginal edges are denuded (Fig. 2). A curved cervical needle, threaded with a loop of silk to draw a silver wire suture in place, is passed through the cervical tissue from a point just within the external os, to emerge near the centre of the raw surface of the incision, then reintroduced and made to emerge upon the mucous surface at a point just above the upper extremity of the incision, or in the posterior fornix of the vagina. A similarly-placed suture is introduced in the opposite side of the cervical incision. When the ends of these sutures are drawn upon the anteflexed cervix is pulled backward, so that the raw surfaces on each side are doubled upon themselves and brought into apposition. It will now be

evident that a cleft has been formed, running from side to side, at the external os, which resembles the cleft between the anterior and posterior lips of the normal os uteri. Supplemental sutures are now introduced on each side of the first, but none of them are twisted into place until an important operation is performed upon the anterior vaginal wall at the point of depression caused by the flexion of the cervix. An incision is made from side to side upon the anterior vaginal surface, to the bottom of the depression, at the point of flexion; this incision is made without cutting into the bladder and not perpendicular to the surface, but runs from before backward and inward, at such an angle with the mucous surface as to constitute a flap,

FIG. 4.



Showing the parts as they appear when the sutures are adjusted.

which can be turned down towards the posterior vaginal wall by means of a tenaculum hooked into its upper extremity. A similar flap is made by commencing an incision in front of the cervix and in a direction toward the bottom of the depression, as before, but upward and inward. When these two flaps are drawn upon, a wedge-shaped piece of tissue is lifted out of an oblong opening extending in depth to the point of cervical flexion (Fig. 3). Sutures are now introduced *across* this oblong opening from one lateral extremity to the other. With these sutures the opposite ends of the opening are approximated, and the cleft is made to run antero-posteriorly instead of laterally, as before. In this way the anterior vaginal wall is lengthened and a splint-like mass of tissue is imposed in front of the cervi-

cal flexion, which tends to prevent a recurrence of the displacement. The wire sutures first placed in the cervix posteriorly are now twisted in place, cut off, and shotted (Fig. 4). A hard-rubber uterine drain is passed into the uterine cavity, to remain for two weeks; the vagina is washed with bichloride solution, after which it is packed with sterilized gauze. The subsequent treatment is the same as that for any other plastic operation on the cervix. The accompanying prolapsus and parametric inflammation will usually require attention after the patient has recovered from the operation. The operation itself cures cervical stenosis, drains the uterine cavity, and may prevent the development of salpingitis. When the appendages are already seriously diseased, it relieves, to a great extent, the pelvic tenesmus and backache. It furthermore leaves the cervix apparently unmutilated, and quite capable of performing its functional action during gestation and at parturition.

---

#### SOME THOUGHTS ON MILK AS A FOOD FOR INFANTS.

BY T. E. PARKER, M.D., WOODBURY, N. J.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Scranton, 1897.)

It has been said there is nothing new under the sun. Before I am through you may think there is nothing new in this paper. My apology is that some subjects very important to physicians are overlooked from their very familiarity, and some very necessary points do not receive proper attention, particularly in Society papers.

In our every-day experience, what annoys or disgusts us more than the way the infant, he who in the fulness of time is expected to make a full-fledged healthy adult, is fed and cared for?

One of the highest aims of the medical art, and one in which the physician must have the co-operation of parent and nurse, is the selection, preparation and administration of the infant's food, that he may be preserved from the perils of the early hours of his existence, and be given strength to resist the attacks that will inevitably be made upon his development.

For one to possess those inalienable rights, life, liberty and



the pursuit of happiness, he must have proper management in infancy. He must be unhindered in his efforts to breathe, grow and live. Nothing must be done to retard his proper development nor in any way embarrass it.

It is the proper or improper food of the very young infant which makes or mars his life, as well as succeeding generations. One little mistake will produce a lifetime of misery.

Who is there who has not had some acquaintance with an old dyspeptic? What more objectionable person can there be to live with?—a half-sick invalid, who sees no pleasure in living, and intends to allow no one else to have any pleasure either. He is too sick to live, but not sick enough to die. His temper is destroyed and soul apparently lost—all these troubles possibly produced by some little error in the nursery. What a responsibility rests upon us! Have we succeeded in meeting it? Has the proper food, other than nature has prepared, been found?

The multiplicity of artificial foods would seem to preclude this idea. Each claims perfection, but the ideal certainly has not been reached.

Human milk, in some instances, has received just condemnation, the mother, either from constitutional derangement or faulty living, having been unable to secrete a fluid for her offspring.

Affluence or poverty, country or city life, are sometimes controlling influences.

Nature has designed that the young of all mammals shall be fed upon animal food; never vegetable.

We cannot improve upon nature's mechanism, but it must not be tampered with; the mother must live in accordance to nature's laws.

The mammary gland, in its normal and perfect state, is a beautiful piece of mechanism, constructed for the secretion of an animal food. When this sensitive machine is out of gear, even in a slight degree, the consequences to the young consumer are disastrous. The breasts are not storehouses, but elaborators and producers. The product is made within the walls and produced on demand. It consists of sugar, fat, and the nitrogenous ingredients, or the proteids, mixed with water and salts from the blood. The nature of this product is easily

changed by outside influences, such as changes in atmosphere, the emotions, fatigue, sickness, etc.

The gland also adapts itself to the demand of the consumer, producing a smaller or greater supply at shorter or longer intervals, according to the age and needs of the child. Improper and irregular intervals change the quality of the milk, longer intervals lessen the solid constituents, while shorter ones increase them. Too long intervals between nursing produce a food too diluted, while too short intervals produce one too concentrated.

The gland, while performing its normal function, is simply a secreting organ; the constituents of its product are not eliminated from the blood, but manufactured within the gland.

During the interval or pause the cells of the gland are growing, and a very small amount of solids is secreted, and a proportionately large amount of water, while the irritation of nursing causes increased activity of the milk-cells, with an increase of the solids and a lessening of the water. Therefore it is found that the first part of the milk contains less fat than the middle or last part. In milkings of two-hour intervals, the fore-milk contains more fat than the fore-milk of twelve-hour intervals; the strippings, or last part of the milkings, just the reverse.

The exact analysis of milk varies in different individuals and at different times in the same individual; but nature has adapted the child to the mother, and the babe cannot be promiscuously changed from the mother's milk to that of another woman. This variation in individuals accounts for the differing analyses we have of human milk.

A mother, to properly and satisfactorily nurse her infant, should be strong and healthy, of an even, happy temperament. Moreover, she should be desirous of nursing her child, and should be willing to devote herself to it as a special duty, and should be willing to regulate her diet, exercise and sleep according to rules that will best fit her for the task.

A cow, to properly produce milk for infants' use, should be healthy, of good milk-producing stock, fed on clean, wholesome food, housed in a clean, well-ventilated stable, and be regularly and properly milked.

The product of the mammary gland is essentially the same in all mammals; the elements are the same, but differ slightly in proportion.

In children, in addition to the materials needed for repair of waste, are those required for the structure and development of new parts; hence a child requires certain materials in larger proportion than an adult.

The essential elements of milk for structural development and food are nitrogens, hydrocarbons or fats, carbohydrates or starch and sugar, the mineral elements, and water. The nitrogenous elements or proteids are used for the structure of brain, nerve, muscle and gland. Nitrogen is essential to every vital process; deprived of it, every function languishes; without it, the child's growth is interrupted, its vigor and vitality is lost, it is pallid and feeble. Fat, like the proteids, enters into every cell. Its chief office is to serve as fuel, to keep up the heat of the body. Children fed with food deficient in fat are slow in growth, bony structures suffer, and rickets results.

If fat is lessened, digestion and nutrition suffer, and there is a tendency to constipation; if there is too much fat, there is another disturbance and a tendency to diarrhœa. Fat is a most vital necessity in infants' food. Artificial foods generally contain too little. The sugars are necessary to the growth, but not in the same proportion as proteids and fats. Phosphate of lime, the most important mineral element, is necessary to every tissue. Water is essential for the solution and carriage of the peptones as well as for other functions.

Milk contains all these elements, and hence is the food *par excellence* for the babe.

Mother's milk does not contain them in the same proportion as cow's, hence the skill and care needed in modifying cow's milk.

In order to keep an adult body in perfect health the elements of the food should be, to every 100 parts: Proteids, 5; fats, 3; carbohydrates, 15; salts or the mineral elements, 1, and water, 76. Human milk, which is the type for infants' food, should contain, according to Luff's analysis, proteids, 2.35; fats, 2.41; sugars, 6.39; salts, .34; water, 88.51. According to Rotch's analysis it should contain: Proteids, 1.50; fat, 4; sugar, 7; salts, 15; water, 87.35. The analysis of cow's milk is: Proteids, 4; fat, 4; sugar, 4.50; salts, .75; water, 86.75. The proportion of fat to sugar in infants' food should



be 1 to 2, while an adult requires it in the proportion of 1 to 9. The proportion of proteids to sugar in infants' food should be 1 to 3; for an adult, 1 to 5.

In every dietary for the adult there is a certain amount of fresh food; the omission of this makes the consumer liable to scurvy. Children fed on fresh milk are not subject to this tendency; hence milk contains some element which makes it antiscorbutic. This element is absent in all farinaceous foods.

The human breast adapts itself to the growth and needs of the infant. At first there is only one pint secreted in twenty-four hours, supplying the child with 1 to 1½ ounces at intervals of every two hours. As the child grows older the amount increases to as much as three pints or more in twenty-four hours. In artificial feeding there is no such guide for the quantity; the needs of the child have to be found out. On the other hand, in artificial feeding the element of interval does not influence the chemical composition of the food.

Breast-milk is always the same, the infant receiving the same food at each nursing. In artificial feeding it is unwise to alternate milk-broths and farinaceous foods. If the child needs anything in addition to the regular milk, these additions must be made at the same time, combined in proper proportion and given together.

During the very early months the child has little power to digest starch, as the diastatic ferment either from the parotid gland or pancreas is not secreted until after the eruption of the teeth. In the natural food-milk there is no starch. The carbohydrate needed is lactine or sugar of milk.

Milk-sugar in milk that is not heated will set up a lactic-acid fermentation, while cane-sugar will set up alcoholic fermentation. Cane-sugar is not assimilated, but acts as a reserve, whereas milk-sugar is utilized in the economy of nutrition. Therefore, on physiological as well as on bacteriological grounds, we are justified in using the same animal sugar as is found in the infant's natural food.

Mother's-milk is alkaline and sterile, and contains, as it comes from the breast, that health-giving principle, vitality. Scientific knowledge has fathomed many a depth, but it cannot give to artificial food that vital element, life. We have not, as yet, been able to follow nature exactly, and therefore have not yet

obtained an ideal method of substitute-feeding. Cow's milk is slightly acid, grows more so, and contains innumerable bacteria; these bacteria are mostly found in the first part of the milking—the act of milking washing out those collected in the mouth of nipple or teat during the interval of milking.

The casein of human milk has a nuclein and peranuclein which are readily assimilable, whereas in the cow's milk the nucleins are partly insoluble and indigestible. The casein of human milk is thrown down in extremely minute flocculent granules readily dissolved by additional fluid, while the casein of cow's milk is cast down in great masses, and is not dissolved by the addition of more fluid. The reason that cow's milk is so much more difficult of digestion than human milk is because of this indigestible casein.

One part water to two of milk would make an analytical preparation similar to human milk, but a child is not able to digest it unless it contains two parts water to one of milk. In this proportion the fat and sugar are far below the necessary requirement. According to Luff, the analysis of two parts of water to one of milk will be: Proteids, 1.46; fat, 1.67; sugar, 1.47, instead of normal milk, according to the same authority, which is: Proteids, 2.35; fat, 2.41; sugar, 6.39; or, according to Rotch, Proteids, 1.50; fat, 4.00; sugar, 7. The fat and sugar alone are below the standard. To bring these two elements up add cream and sugar. Cheadle, an English authority, recommends bringing up the proteids by adding raw meat-juice and breaking up the hard casein by the addition of barley-water.

In preparing a meal for adults whose stomachs are thoroughly developed, and in many cases tough enough to digest anything that enters them, the cook spends hours in carefully cooking and preparing the meal. How much time does the usual attendant spend in getting the food ready for the little one, whose stomach and whole constitution is in a frail, undeveloped condition? Most all adult food is well cooked, or, in other words, sterilized. Mother's milk is sterile; cow's milk, in certain conditions, is teeming with bacteria. No food is properly ready for the baby until it is previously made sterile. Bacteria will not thrive in a temperature below 60° F. nor in that above 167° F., except the bacteria of tuberculosis and anthrax. These two germs require a temperature of 212° to destroy them.

Bacteria hasten the acid fermentation of milk, hence their growth is retarded in a temperature below  $60^{\circ}$ .

Cheadle recommends the boiling of all milk to sterilize it. The scum, he goes on to say, that rises to the surface should be skimmed off to render the milk more easily digested, by reducing the amount of hard curds, as these curds are composed of hardened casein, and the indigestible casein is thereby reduced.

American authors believe that boiling radically changes the constituent parts of the proteids, and produces a food unfitted for the use of the infant.

If sterilization is the destruction of living germs, a temperature less than the boiling will answer. The method I prefer is that of Professor Rotch of Boston, which is to place the modified milk in bottles, enough in each bottle for one feeding, set the bottles in a pan of cold water, bring the water to a temperature of  $170^{\circ}$ , then remove all from the fire, allowing the pan containing the bottles to remain covered for half an hour. The temperature at the end of the half hour will generally be as high as  $167^{\circ}$ , which is sufficient to kill the majority of germ-life.

Rotch also gives as a safe formula for the average babe 2 ounces milk, 3 ounces cream, 10 ounces water,  $6\frac{3}{4}$  drachms milk-sugar; steam twenty minutes, then add 1 ounce lime-water. These proportions should be changed to conform to the age and needs of the child. Lime-water is not always needed, but cow's milk is acid and it must be made neutral or alkaline similar to mother's milk. The bicarbonate of soda can be used instead of lime-water. Cow's milk does not always give satisfaction, the milk as cow's milk is condemned. We change to some artificial food which is totally dissimilar to nature's food, a food probably made from cereals, dried milk or what not, made to keep, not to nourish. The fault may not have been in the milk as milk, but in the management of the cows, the care of the milk before reaching the consumer, or in the modification and preparation of the milk.

If we can obtain milk from good healthy cows whose milk analysis is neither too rich nor too poor—cows that are kept and cared for by an intelligent, honest dairyman; that are fed in summer on good upland pasture, where there is pure water to drink and plenty of shade; that in winter are kept in clean,



well-ventilated and warm stables, that are carefully and thoughtfully groomed, fed on good milk-producing food, with the milk cleanly drawn and cared for; in short, cows and milk treated intelligently, if not scientifically—we may find a milk not far from the ideal in many cases. All this care on the part of the dairyman may be rendered of no avail by the slightest neglect on the part of the person who has the oversight of the milk for the child. The milk should be kept in a cool, clean place, should be properly modified and prepared in bottles that have been thoroughly cleansed and aired, and having perfectly sweet nipples. It is also important to feed the child at regular intervals, and with the proper quantity of food.

While practising in New Hampshire we were confronted with cows fed upon the mountain sides which were covered with a coarse grass that in dry seasons was a prolific source of trouble. In New Jersey I find an equally objectionable feature in those fed in low marshes.

In the counties of Pennsylvania around Philadelphia, the ones I am most familiar with, we find many pastures along creeks, containing buttercups, iron and other noxious weeds, which are another source of trouble.

Even if the mammary gland does not excrete from the blood the constituents of the food partaken, the kind of feed does have a wonderful controlling effect upon the product obtained, and we are accordingly confronted with milk, either suitable or unsuitable for the babe.

During the dreaded dog-days we have another obstacle in the shape of dry weather, with poor crops, hot days, and plenty of flies to annoy the cow. Then we find a lessening of the milk produced, and, judging from butter-makers, a lessening of the fat-globules. During a wet spell we have a luxuriant growth of weeds to annoy us.

When we can educate the milk-producer, the milk-dealer, the milk-modifier and the milk-feeder to the better observance of correct and proper rules, we shall obtain a food from our native and domestic cow better than we find to-day.

Who can expect success from feeding a babe upon any and every kind of milk, from a sour, fly-infested bottle, when we know that lactic acid sets up in the bowels a fermentation, and this fermentation is a good soil for the germ that we urge the

poor little helpless innocent to partake of, or who, else, succumbs to the pangs of hunger ?

Kind Providence is merciful, but when he endows and furnishes us with brains he intends us to use them, and not insult him by going contrary to his laws and the laws of common sense which he has given us.

---

### MEASLES.

BY WALTER SANDS MILLS, M.D., NEW YORK CITY.

(Assistant Visiting Physician, Metropolitan Hospital.)

(Read before the Connecticut Homœopathic Medical Society, Bridgeport, October, 1897.)

MEASLES, rubeola, or morbilli, is an acute infectious disease involving the skin and mucous membranes. It runs a characteristic course of invasion, eruption, and desquamation, usually lasting about fourteen days. In my cases the time from the beginning of invasion to the end of desquamation varied between twelve and eighteen days.

The cause of measles is supposed to be a specific germ. Up to the present time, however, it has never been isolated. Several investigators have reported the discovery of a measles bacillus, but their claims have not been substantiated. The eruption is not found in the dead subject, and Flint\* says there is no specific anatomical characteristic.

Whatever the cause may be, the disease is, next to small-pox, the most contagious that we have. It is communicable from the beginning of invasion to the end of desquamation. The contagium is less persistent than that of either small-pox or scarlet fever. It may be transmitted by fomites. A physician, if not careful, may carry the disease from one patient to another. Whenever I have to call on a patient ill of a contagious disease, it is my custom to wear into the sick room a linen duster. The first cost of such a garment is small, and it is easily kept disinfected.

In an epidemic of measles occurring in a boarding-school at Stamford in the spring of 1896, the first patient had, during

---

\* *Practice of Medicine*, Austin Flint, M.D.

vacation, been in letter-communication with a cousin down with the disease. The two correspondents were at the time more than a hundred miles apart. The school patient was taken ill shortly after her return from her holiday. The next half-dozen patients were all on terms of osculatory intimacy with the first. The other girls, whom she met only in the ordinary way, in the class-room and in the dining-room, escaped this source of infection.

The period of incubation averages about ten days. It may be but four days—it may, very rarely, be as much as thirty days. After a child has been exposed to measles, at least a full fortnight should pass without the exhibition of any catarrhal symptoms before we can feel assured that the disease will not develop. One of my patients, a little girl, came down with rubeola in exactly seven days after the beginning of invasion in an older sister. The older child had been isolated immediately, and the younger given *pulsatilla* as a prophylactic—but without success. There are no observable symptoms during the incubatory period.

The stage of invasion is ushered in with all the symptoms of an influenza. The patient has coryza, the eyes run and are sensitive to light, there is pharyngitis and laryngitis, with hoarseness, and bronchitis, with a dry cough. The patient feels chilly, but has no distinct rigor. The temperature runs up to 102° or 103° at the onset, to drop a little the succeeding days, until the eruption appears, when the temperature again rises. The tongue becomes covered with a thick, white fur, the tip and edges remaining red. Epistaxis sometimes occurs. Convulsions are rare.

Usually, about the third day—it may be the second to the sixth—the eruption begins to show itself. It appears first in the buccal cavity on the soft palate, uvula, and mucous membrane of the cheeks. One of my cases presented an acute pharyngitis when I first saw her, together with a slight coryza, but I failed to note any eruption until it appeared on the face. Another patient, whom I had an opportunity to watch carefully from the beginning of incubation, showed the eruptive spots on the pharynx and roof of the mouth on the third day of invasion.

From twelve to twenty-four hours after the appearance of the



eruption in the mouth it begins to show itself on the skin. It appears on the face, then on the chest, arms, and legs, in the order named. It is said to come first on the forehead, but in two of my cases the cheeks were first attacked. The eruption consists of minute round papules, which can be felt before they can be seen. At first they are distinct, but soon they form themselves into groups or patches, with curved or crescentic outlines. The color of the skin is not uniform, but has a mottled appearance. The rash is dark red and disappears on pressure. It takes thirty-six to forty-eight hours for the body to become completely covered. The eruption remains at its maximum about twelve hours, and then begins to decline. The whole stage lasts about four days—perhaps less, rarely more.

During this period of the disease lachrymation and photophobia are more marked, the cough increases and becomes looser, and there is more or less expectoration. The temperature begins to rise as the rash appears, and reaches its maximum—it may be  $105^{\circ}$  or  $106^{\circ}$ —when the rash is greatest. The papillæ of the tongue become enlarged and red, and show through the white fur. The skin appears red and swollen with the eruption, is hot and dry, and sometimes there is intense itching. The patient is restless at night and drowsy by day. The appetite is lost and the patient is very thirsty. Occasionally there is delirium. It occurred in one of my cases.

The stage of desquamation lasts from four to eight days. It begins when the rash begins to fade. All the symptoms decline as the eruption disappears, expectoration becomes rumular, the temperature falls by crisis. The skin does not peel off, like in scarlet fever, but is given off as fine bran-like particles. Convalescence is rapid. In ten to fourteen days from the onset of invasion the patient is practically well.

The above is the history of a case of ordinary measles. The disease may present itself in an anomalous form. The rash may be hæmorrhagic in character, the so-called “black” measles. During epidemics occasional cases are seen that exhibit all the symptoms excepting the rash. Such cases are usually very mild. We may also have the rash without the catarrhal symptoms. Again, cases may run the usual course excepting that all symptoms appear to be very much aggravated. True relapse in measles is extremely rare. As a rule,

measles occurs but once in the same person. Exceptions are numerous; I have myself taken one patient through three attacks, and some of my other patients had had the disease before I treated them for it.

The complications of measles are numerous. Those of most importance are of the respiratory or digestive systems or of the eyes. Catarrhal symptoms of the eyes, nose, throat and bronchial tubes always accompany measles, and are a part of it, but, unless of extraordinary severity, such symptoms ought not to be classed as complications. Diarrhœa is a frequent accompaniment of measles, although in my cases it has but seldom been severe enough to rank as a complication. Stomatitis is a usual companion of rubeola, and may be severe enough to call for special attention. Inflammation of the middle ear also occurs with measles; usually it does not develop until the stage of desquamation. Many other things may complicate measles, but the ones mentioned occur most frequently and are of most importance. It should not be forgotten that other diseases may appear, and they should be watched out for.

Some of the complications of measles run on and become sequelæ. Capillary bronchitis is one of these, and a serious one. I lost one patient by it. Pneumonia occasionally follows morbilli. The sequelæ most to be feared are various forms of tuberculosis. Miliary tuberculosis, especially in young children, follows measles with comparative frequency. Chronic phthisis may have its origin in measles. The accompanying bronchitis may run into a chronic condition and continue for months. Chronic catarrh of the middle ear is another legacy of measles, although it does not follow measles as often as it does scarlet fever.

The diagnosis of measles, during invasion, may be confounded with influenza. The subsequent course of the disease will leave no doubt as to its character. In the midst of an epidemic of rubeola the catarrhal symptoms will, of course, excite suspicion.

In measles the catarrhal symptoms and the temperature usually subside on the second day, and the patient feels comparatively comfortable. This has led, at times, to a confounding of measles with malaria.

Rötheln, or German measles, may be mistaken for rubeola.

The German variety has no stage of invasion, no stage of desquamation. The eruption appears at once, and is paler than that of measles. As a rule, the spots are fewer, and do not tend to coalesce. There is apt to be sore throat.

In scarlatina the onset is more sudden than in measles, and the evidences of systemic poisoning are more marked. The pulse is rapid, there is usually vomiting, a true angina supervenes, the catarrhal symptoms are lacking, and the eruption comes on within twenty-four hours. The scarlet fever rash is more of a diffuse redness, and the color is a bright scarlet. When in patches the outline is irregular, whereas in measles it is crescentic or curved.

Variola presents lumbar and sacral pains in the beginning. Unlike measles, the temperature drops on the appearance of the rash. The rash itself is vesicular, and appears earlier in the disease.

The prognosis of measles is good. Uncomplicated cases usually recover. Enough deaths occur, however, to require the practitioner to exert his utmost skill in handling the disease. According to statistics presented by Fisher\* the actual number of deaths from measles in 1893, in Chicago, was 234. This number was exceeded only by the deaths from scarlet fever and from diphtheria. Figures given to me by Dr. E. C. M. Hall, and presented in a previous communication,† show that 53 deaths from measles occurred from 1891 to 1895, inclusive, in New Haven. Of 286 cases reported by old-school physicians, 51 died. Of 106 cases reported by homœopathic physicians, 2 died. These last figures also show that the prognosis is influenced by the treatment. The death-rate under old-school treatment was 17.83 per cent., whereas under homœopathic treatment it was but 1.88 per cent.

The complications and sequelæ of measles are responsible for more deaths than the disease itself. Personally, I have lost one patient, a child of six months, who died from capillary bronchitis following measles on the fourteenth day from the beginning of the disease. After an extensive epidemic of

---

\* *Diseases of Children*, Charles E. Fisher, M.D., Chicago, 1895, Medical Century Co.

† "Some Reasons for a Belief in Homœopathy," Walter Sands Mills, M.D., *New England Medical Gazette*, October, 1896.



measles the mortality among children has been found to exceed the average.

The first thing to do when measles is suspected is to isolate the patient. He should be put into a large, easily ventilated room. On account of the accompanying conjunctivitis the room will have to be kept somewhat darkened. Other children who have come in contact with the patient should be carefully watched for catarrhal symptoms. Some homœopathic physicians have advocated giving the remedy used in cases of the disease as a prophylactic to children who have been exposed. I gave *pulsatilla*, with this object in view, to four patients. Two escaped; two had the disease, with aggravated respiratory symptoms. One of these last was the infant that died.

At the end of the illness, and before the patient is allowed to mix with other children, a warm bath should be given. This is done to cleanse the skin of any desquamating particles that might otherwise serve as sources of infection. Hardaway\* says the measles patient should be quarantined for forty days, but that seems to me to be unnecessarily long. I do not believe contagion to be possible after desquamation has ceased, and that ought to be in much less than forty days.

The diet should consist of milk, gruel, eggs, meat-juice, and so on. Water may be given *ad libitum* for the thirst. One of my patients had severe gastric disturbance, with vomiting. Milk, or milk with seltzer, could not be retained. I had to have recourse to milk with lime-water. The vomiting did not appear until the third day of the eruption, when the rash was at its height. The temperature rose to 103°, and there was delirium at night.

During the fever the patient may be given sponge baths. Artificial steam will often do much to palliate the respiratory symptoms. A sponge soaked in very hot water applied to the throat will relieve croupy symptoms. In the eruptive stage, if there is much itching, carbolized vaseline will help it. If the rash is not profuse, or should recede, look out for complications and treat the case symptomatically. Do not try to "bring out" the rash. I believe a suppressed eruption to be an effect, not a cause. There is usually more or less stomatitis; for that,

---

\* Hardaway, in Pepper's *System of Medicine*.

a mouth-wash is desirable. An antiseptic mouth-wash is also said to kill pneumonia microbes, and thus assists in preventing that disease from becoming a complication. A solution of boracic acid, or of the alkaline borsolyptus, may be used. This last is, pharmaceutically, an elegant preparation, and leaves a pleasant taste behind it. It is antiseptic and alkaline.

In otitis a spray of warm boracic acid solution, or of cocaine, will relieve the pain. Mullein oil, or plantago, may also prove useful. If otorrhœa comes on in spite of treatment, I use a wash devised by my friend, Dr. George A. Shepard, of this city. Take a 2-drachm vial, fill it one-third full of powdered boracic acid, drop sufficient alcohol on the powder to moisten it, and fill the bottle with distilled water. Cleanse the ear thoroughly with absorbent cotton, then insert cotton saturated with the solution, and leave it. Dress every eight to twelve hours, as necessary. The results are unsurpassed by any treatment with which I am familiar.

Of drug treatment in measles, old-school authorities say none is necessary. The homœopath, however, will find that his indicated remedy will help him here as elsewhere. I will mention only the drugs, with the potencies, that I have myself prescribed. I have neither the time nor the inclination to name all the remedies that might be used.

I have found *pulsatilla* 3 to be the most generally useful drug. It fits nearly all the symptoms to a nicety. It is pre-eminently a catarrhal remedy, and is called for in the stage of invasion and in the stage of eruption. It is also of great service when diarrhœa supervenes.

*Aconitum* 1 I have used advantageously in the beginning of measles with severe inflammatory symptoms, accompanied by rapid pulse.

*Gelsemium* 1 I have found useful where the coryza was marked, and the patient in an apathetic or nervous condition.

*Kali bichromicum* 6 is useful for the cough, and for the bronchitis. It has proved of great value when these symptoms were severe.

I have also found *antimonium tartaricum* 3 of service in the cough of measles.

*Arsenicum album* 3 served me well in the case mentioned where the gastric disturbance was marked.

If otitis occurs, *ferrum phosphoricum* 6 should be given. It usually stops it.

When the inflammation goes on to an otorrhœa, *calcaria picrata* 3 is my remedy.

I have also given *hepar* 6 for the ear complications. It is of service both before and after the discharge appears, whereas *ferrum phosphoricum* is most useful before, and *calcaria picrata* is most useful after the otorrhœa sets in.

I have used a few other remedies in various cases, but the ones mentioned have been my main reliance, and have seemed to me to do the greatest amount of good. I sometimes alternate my remedies, but never have done so in measles. My medicines were all given in water, a dose every one to two hours, according to the severity of the symptoms.

---

## IS THE PRESENT HIGH RATE OF INFANTILE MORTALITY NECESSARY?

BY A. W. BAILY, M.D., ATLANTIC CITY, N. J.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Scranton, 1897.)

BUT few children are born with nature's edict resting upon them that they must die in infancy. The economy of nature knows no lavishness at the expense of human life. She has no children to wantonly sacrifice, she recognizes no overproduction, and infantile mortality as it now stands upon our records is due to some cause other than the decree of nature.

For several years I have been watching and compiling the death-rates of some of our larger cities and towns, and the results show that 44 per cent. of all deaths occur under the age of five years, which simply means that of every hundred infants born, forty-four of them never reach the close of the fifth year. This is truly an immense loss of life, and the inquiry is naturally raised, Can it not be prevented?

The records are far from being complete, and he who would make a careful study of the true cause of infantile mortality has many tangled webs to unweave. Five per cent. of all infants who die are either still-born or die from premature birth, and 7 per cent. are born with some constitutional taint that



carries them off under five years of age. This, then, leaves out of the 44 per cent. that die, thirty-nine healthy infants in every hundred born who have as much right to live and develop as the other fifty-six healthy ones; but they die an untimely death. Some cause must be assigned for this, and in order to discover it let us investigate closely the causes of death.

The causes of death I have divided into seven classes, namely, (1) premature and still-birth; (2) constitutional or hereditary disorders; (3) contagious diseases; (4) diseases of the nervous system; (5) of the respiratory tract; (6) of the alimentary tract, and (7) miscellaneous. This division is to a degree arbitrary, as the cause of death recorded may be secondary to some disease in another class, but owing to the lax manner in which many of the records are kept and published this difficulty cannot be overcome.

Premature and still-birth are responsible for the death of two out of every hundred children born. With those who are still-born the physician perhaps has but little to do, save to certify to the fact and turn them over to the undertaker. Premature birth demands a little more attention, for at least a small percentage of these untimely births can be prevented, and the mother, by proper care, helped to go to full term.

Constitutional or hereditary taints are accountable for the death of three out of every hundred children born. Under this head are classed all diseases of a tubercular diathesis, malformations, cancer, scrofula and congenital syphilis. That one child out of every thirty-three should die of some disease transmitted to it by one or both parents is far too large a proportion, and demands our attention. Whether those who are suffering from tubercular or syphilitic disorders should have progeny on whom to inflict their diseases is a vital question of social economy. Personally, I believe they have no moral right to offspring until they have been put in such physical condition that healthy children can be reasonably expected.

But I will admit, if you so desire, that these five children out of every hundred cannot be saved; but what of the other thirty-nine who are born healthy but die under the fifth year? I believe that many of these deaths are entirely unnecessary, and are due to neglect, carelessness or ignorance on the part of some one.

Fourteen per cent. of infantile mortality is due to contagious diseases. In this class are included diphtheria, scarlet fever, measles, small-pox, whooping-cough, croup. As a preventive to contagion, isolation, more or less perfect, is practiced. Often isolation is more in name than in fact, for there is often too much carelessness regarding it. Those who are liable to exposure should be surrounded with an abundance of the purest air that can be secured. Parents often do not appreciate the value of pure out-door air in protecting their children. The infant and adult are not treated alike in this matter; the one is kept in the house, protected from the outside air, especially if it be a little cool, while the youth and adult go out freely. This is hardly just to the baby, for it should have at least as many chances for life as the adult. How many of us can recall a dozen houses among the homes of our patients where the nursery is the most cheerful and sunshiny room in the house? Germs entering a room with an elevated temperature (and the nursery is very frequently too hot) and a lack of abundance of sunshine will develop quickly, and the child playing in such an atmosphere becomes an easy prey to contagion. Parents need to have the truth impressed upon them that pure air and sunshine are the best antidotes for disease.

The same thoughts can be expressed in almost the same words regarding the prevention of diseases of the respiratory tract. Living in a vitiated atmosphere, which is too hot and too dry, lays a foundation for future trouble. The mucous membrane is kept in an irritable condition, nerve-force is depleted, powers of resistance lessened, and some unavoidable or accidental exposure results disastrously. I do not believe in reckless exposure, neither do I believe in the other extreme; for there is a happy medium which, if it entered the life-history of more infants, mortality from diseases of the respiratory tract, which now represents 17 per cent. of the death-rate, would be greatly reduced.

Nervous diseases claim 18 per cent. of infantile deaths. These diseases, especially convulsions, are frequently secondary to other disorders, and one-third of all deaths attributed to nervous causes result from convulsions. Many of these, therefore, should be credited to some irritation of the stomach and intestines, and as such should be classed as preventable.

But the greatest factor in infantile mortality is that group of disorders which disturb some portion of the alimentary tract; they are guilty of more than one-third the death-rate, 34 per cent. At the head of the list stands cholera infantum. Heat is credited with being the great predisposing cause of all disorders where diarrhœa is a pronounced symptom; but there are other causes as ripe, and more sure in their effects, and first among these I would place diet. A sudden change of diet, spoiled food, unripe fruit or vegetables, indigestible or poorly prepared food will frequently engender a condition of the stomach and intestines which only requires some little cause, as a suddenly hot day, or the protrusion of a tooth, to produce a stubborn and perhaps fatal diarrhœa. Diet is one of the greatest and hardest questions the physician must solve in these cases. What food shall baby eat? The old monthly nurse, of course, knows all about it, and too often the question is left for her to settle for the first week or ten days, till the baby becomes fretful and troublesome, and then the doctor is requested to give the baby something to make it sleep. Of course there is indigestion and looseness of the bowels. The seeds of disease are often planted before the baby is six hours old. The old nurse declares it is hungry, and immediately stuffs it with sweetened water, brandy and water, gin and water, milk and water, catnip tea, and a score of other diabolical mixtures; and right here will be found the beginning of many cases of indigestion that end in diarrhœa, inflammation and death. The obstetrician has not ended his labors and should not leave the house till he has given strict orders regarding the baby's diet. When the mother has a full breast of good milk the question of diet is easily settled, and the only thing to be determined is the time for nursing; but sometimes nature does not supply the expected food, and a substitute must be secured. Of these there is no end, and each one is better than all the rest, being the only perfect substitute for mother's milk.

There is no perfect substitute for mother's milk. Good cow's milk is the best we can secure, but the casein often causes trouble. True, this can be modified, and herein lies one of the opportunities of the physician to reduce the mortality-rate. Of the many articles of food upon the market, some are useful in helping digestion, some contain a good deal of nutritive ma-



terial, and some cannot be too strongly condemned. Especially do I condemn all milk powders, no matter by what name they are called or by whom they are manufactured. In order to evaporate the milk to dryness all the oil must be removed, and there is nothing but the casein and salts left. Milk powders are simply evaporated skim-milk with the nutritive properties of grain added. This simply means pulverized cheese. My experience with this class of foods has been disastrous, and I am satisfied that many an infant has lost its life through their use. You may answer that some babies thrive and grow fat upon them; I have seen babies thrive who have been fed upon bananas and peanuts, but their number is very small. All the milk in these so-called milk powders is harmful; the food would be more nutritious without it, and the child who thrives upon them does so in spite of the cheese.

Under miscellaneous diseases we have a heterogeneous collection, comprising heart and kidney complications, primary or secondary; miasmatic diseases, erysipelas, hæmorrhage, accident, violence, and a number of more or less rare troubles. Altogether, this class is responsible for 5 per cent. of the death-rate.

How many children do we see die every year whose death can be traced to the neglect, ignorance or thoughtlessness of some one. We can number them by the score. Exposure, too much or too little clothing, improper diet, neglect or too much questionable care and kindness, each year secures its victims from among our babies, and we have grown too accustomed to the little coffin and white crape upon the door; we have grown to feel that this is one of the sad scenes of life which we must endure without hope of redress. The minister speaks of the mysterious workings of an all-wise Providence, when perhaps the trouble was catnip tea, Alderney milk, candy, bananas, peanuts, potatoes, short stockings, low-neck dress, an habitually too hot nursery, or a hundred and one other preventable causes. There is no necessity for the present high rate of infantile mortality, except that which is found in pride, ignorance or neglect.

## EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

## A MISCONCEPTION.

IN the *American Journal of Surgery and Gynecology*, of St. Louis, there appears an editorial article which deserves comment at our hands. It is interesting as showing a gradual awakening of a more liberal spirit in some quarters of the medical world, and important as demonstrating an essential misconception of the true situation of affairs, and of the position held by Homœopathy.

The editorial is a truthful and forcible arraignment of the "inclination to degeneracy" manifest everywhere in the body medical. Evidences of this it finds, first, in the prevailing "business" commercial spirit which has taken possession of what was once a liberal profession. The trade-spirit is shown not only by the struggling masses of the rank and file, but even by those would-be leaders who should be foremost in upholding the dignity and honor of their calling. It finds evidence, further, in the unethical vilification and abuse of the "homœopaths" and "eclectics" by members of the "regular" profession, and, finally, in the condition of the advertising pages of so many medical journals, which indicate that all sorts of unknown compounds and proprietary remedies are prescribed by medical men who, by doing so, prove "that they are becoming careless of their professional honor and unmindful of their own good, and insensible of the great downward plunge they are taking thereby."

Although these criticisms are directed particularly against the branch of the medical profession to which the author of the editorial in question belongs, we are not in a condition to declare that our own branch is entirely blameless; but "that's another story," and we must just now confine ourselves to the "abuse of homœopaths" and the proposed remedy. The editorial says: "The old plea that homœopaths and eclectics are ignorant, or not well-grounded in the fundamental branches of

medicine, no longer holds good. Their course of instruction was just as thorough, just as liberal, just as complete (except in the one item of *materia medica*), and the terms of admission to the school probably even higher than those which governed the others." To bar such, in spite of their personal worth and integrity and professional honor, from membership in local or State medical associations because these bodies would presumably forfeit their right to representation in the American Medical Association by their admission to membership, it says, "is not right. It is not 'ethical' in the ethics of common sense, of common decency, or of common manhood."

This is surely a candid, manly, honorable sentiment, which we welcome and appreciate, and which we trust may in the near future become more general; but let us examine the remedy proposed.

The editorial goes on: "Let every city and county medical society in the country which is in affiliation with the American Medical Association pass this resolution, and instruct its delegates to vote for it:

*"Resolved*, That henceforth all local and State medical societies in affiliation with the American Medical Association be permitted to admit to full membership any graduate of a reputable homœopathic or eclectic college who is an honorable man, a conscientious practitioner, and who does not use the name 'homœopath' or 'eclectic' upon his sign or card, or in any other manner calculated to secure business upon the assumption that he is practising some peculiar system of medicine."

In the first place, we are not aware that homœopaths are clamoring for admission to medical societies in affiliation with the American Medical Association, and, therefore, the setting up any condition preparatory to their admission is, to say the least (we say it with all kindliness), a little "previous."

And what is the condition proposed? We have no end of pity for those few who have in the past felt compelled, after years of the practice of homœopathy, to sever their connection with the school. They have therewith confessed their own past blindness, incompetency and self-deception. All that they had done as homœopaths was to be regarded as false and irrational. Their cures were not cures, their efforts were futile,



their dead were murdered. In comparison with such an acknowledgment, the proverbial "eating crow" must be regarded as an agreeable pastime. And yet such would be demanded as a condition for admission to the societies of our brethren of the other school.

In those who have never practised according to the principle of Homœopathy, who have never sought to apply it, who have never been convinced of its general applicability, it would cause but few qualms to throw down a standard they have never upheld, a standard they have never honored. But who of those that have seen the beneficial results of the application of remedies according to the principle of Homœopathy, who have been willing to recognize that, where it seemed to fail, the fault might lie in their own limited knowledge, would be willing to renounce their allegiance to it, and to pass "under the yoke" into the camp of their whilom enemies?

The proposition, made in good faith, and in the supposed interest of liberal medical science, is based upon a misconception, a misconception for which we homœopaths are in a great measure responsible. There can be no doubt that in the beginning the claims made for Homœopathy were excessive and extravagant. With the gradual spread of medical science in all directions this was recognized, and a reaction set in, and from all sides were advanced limitations to the applicability of the law of similars. These limitations, in their turn, have become excessive and extravagant, and we have, in the minds of many, the sphere of Homœopathy whittled down to a very fine point. The desire to be considered "liberal" and "scientific" has, on the one side, brought it about that these limitations have been loudly heralded, and their adoption loudly boasted of, while, on the other hand, the fear of being thought "unscientific" and "behind the times" has kept the efforts to discover the true principle of limitation in the background.

The truth of a system, be it medical, theological or any other, ought never to be estimated by the practice of its professors. Were we to judge of the truth of the fundamental tenets of Christianity by the practice of its adherents, where would we be? A system must be judged by its own inherent merits or demerits.

The vast amount of testimony, furnished from all sides, to

the effect that cures of curable conditions are most frequently, if not exclusively, brought about in accordance with the law of similars, dare not be set aside, no matter how often the professors of this belief depart from it in their efforts to produce striking results or to avoid the study necessary to apply it. The old school are in a great measure justified in their criticism that much of the practice of homœopaths is along the lines laid down by their own authorities, and therefore we cannot find fault with their deduction that, for many, the name "homœopath" is a misnomer, and one which in honor should be dropped; but that does not justify them in maintaining that all calling themselves homœopaths practice in this way, or that Homœopathy has proved a failure. The proposition in the editorial under consideration could be adopted only by some, and if carried out would still leave a large body of successful practitioners who are by no means ready to abandon their standard. Even in our own school the constitutions of most, if not all, of the medical societies would, if strictly enforced, exclude the same class as would be likely to seek entrance into the societies of the "old school." A truly liberal medical spirit could only result logically in striking out of the constitution of every medical society, homœopathic as well as allopathic, every reference to the therapeutic views of its members; and with a proposition looking to this end we would be heartily in accord. Let entrance to a scientific medical body be conditioned only on the possession of a good moral character and the requisite medical training as evidenced by the diploma of a reputable medical college, and let each individual then select for his associates those with whom he feels most in sympathy. We believe that this, in the present state of medical science, would tend best to the development and building up of a truly scientific Homœopathy—one which would eventually command universal recognition.

In reading the proceedings of our various societies are we not constantly brought face to face with the fact that most of our exploited progress is in the footsteps of the leaders of our brethren of the opposite school? Of course there are honorable exceptions, which we gladly and thankfully recognize, but the general trend of activity is in lines lying outside of homœopathic therapeutics. With the intense ardor shown in

the cultivation of specialties, we had hoped to find a corresponding development of Homœopathy in its application to these; but we find, alas! too often only a servile imitation of the methods of the other school. When we note the constantly increasing borrowings (others call them "thefts") of our methods in therapeutics, on the part of many of the advanced members of the "regular" profession,\* we blush to think of the utter want of originality shown by many of our leaders in the treatment of conditions surely falling within the scope of true Homœopathy.

These things ought not to be so. Homœopathy is not a dead issue, nor yet an expired trade-mark, and its adherents are not all either knaves, trading on a name, or fools, following an antiquated delusion. Let our hospitals and dispensaries be utilized, not to test every new, untried allopathic preparation, but to prove that there is in Homœopathy a distinct advance in the science of therapeutics over the empirical practice of the old school. Were half the time now spent in discovering minute points of differential diagnosis to be verified by a post-mortem, or in seeking to keep track of the ever-varying suggestions of a lawless empiricism, spent in studying up the cases to find the curative remedy homœopathically indicated, suffering humanity would be better served, and Homœopathy more highly honored.

---

THE SEMI-CENTENNIAL OF HAHNEMANN MEDICAL COLLEGE,  
PHILADELPHIA.

IN connection with the elaborate ceremonies celebrating the Golden Jubilee of the Hahnemann Medical College of Philadelphia, arrangements have been made to hold "a Medical Educational Congress" on Wednesday, May 11th, and Thursday, May 12th, 1898, the sessions being devoted to papers and discussions by the most noted teachers of homœopathy in the world upon the following subjects:

Wednesday morning: 1. The Use and Abuse of the Didactic Lecture. 2. The Place and Value of the Laboratory in Medi-

---

\* We would commend for careful perusal a paper on "A Quarter Century of Allopathic Progress, Viewed Homœopathically," by W. A. Dewey, M.D., in the *Medical Century* for March 1, 1898, just to hand.



cal College Instruction. Afternoon: 3. How can the Specialties in the Students' Course be made to Promote their True Objects? The Efficiency of the General Practitioner. 4. The Place and Extent of Clinical Teaching in a Four-Year Course. Evening: 5. What does the Medical College need at the hands of the Literary Schools?

Thursday morning: 6. Do the Conditions of Education in the United States necessitate the establishment and maintenance of Preparatory Courses in Medical Colleges? 7. To what extent should Preparatory Studies be admitted to the present Four-Year Course?

The Faculty and Trustees extend a cordial invitation to all interested to attend and take part in the discussions.

---

#### THE HAHNEMANN MONUMENT.

IN these days of patriotic unity of action it will be well for homœopathic physicians to give up a few minutes to sober reflection upon the Monument which our honor is pledged to erect in the city of Washington in the near future.

The committee in charge has been working ceaselessly in season and out of season, but at present they are wretchedly handicapped by want of proper financial support. Resolute in purpose, their courage and devotion has never faltered during all the weary days of financial depression, and they have been able to gather sufficient means to nearly complete the statue. Their magnificent perseverance should inspire us to action for their relief, and we can exhibit our appreciation of their splendid effort and unremitting toil in no better way than by doing exactly as is requested by them in the following excerpt, taken from a recent appeal for aid to complete the Monument at once. There is no time for hesitation. What somebody else has done or is doing is of no consequence. Subscribe yourself; and if all will do likewise, a Monument of elegant artistic merit will soon be found at the Capital of the Nation.

The Monument to Hahnemann, unequalled in this country and unsurpassed anywhere as a work of art—already famous, is now nearly completed. The granite work from the quarries of the Maine and New Hampshire Granite Co. has been finished, with the exception of some of the finer carving and the letter-

ing. The statue and bas-reliefs have been cast in bronze by the Gorham Mfg. Co., and will be exhibited at the several Art Exhibitions this season in New York. It is not designed alone to honor the Leader of a great reformation and founder of a school of medicine, but also as an enduring monument to the stability and growth of our method of cure—directing general attention to our existence, exerting an influence on local recognition and legislation, and strengthening our position everywhere in this and other lands.

It must be borne in mind, however, that whatever its noble purpose, it cannot be erected until the necessary funds are in hand to pay for it. For the credit of each of us, personally and professionally, therefore, the balance of this fund must be raised without further delay. The name of every homœopathic physician in the United States should be on the roll of subscribers that is to be placed in the corner-stone.

The purpose of this circular is to suggest and urge a plan by which every member of the profession can have a part in erecting this great memorial. It is accordingly proposed to inaugurate a uniform subscription of \$5.00 in honor of *Hahnemann's Birthday*.

Many who have already subscribed liberally may again show their devotion to the cause by making this *special* contribution; and many who expect to give more later on will now come forward to the help of the Committee in this emergency. If this movement is universally observed, no *further contribution will be necessary*. It is urged upon each physician that he make use of the enclosed envelope and blank for this purpose at once. A day's delay may lead to the neglect of this very ready means to a great end. The amount is not large for each, but if all respond it will be sufficient.

J. H. McCLELLAND, M.D., *Chairman*.

HENRY M. SMITH, M.D., *Treasurer*,  
288 St. Nicholas Ave., New York.

---

FIBROID TUMORS OF THE UTERUS.—(Hanks.) He depreciates Apostoli's method of treatment by galvanism, and states that a far greater per cent. than the cures were permanently injured by the strong currents of electricity used. If the uterus and tumor is not more than three inches in its antero-posterior diameter, in a woman with a full-sized pelvis, and the cervix can be easily drawn down near the vulva, the vaginal operation is to be preferred. He uses the scalpel or scissors for the vaginal incision around the cervix in fibroid cases, and the thermo-cautery or galvanic-cautery wire for cases complicated by cancer. He clamps the uterine and ovarian arteries. Unless the tumor can be easily drawn below the brim of the pelvis this operation should not be attempted, except by a skilled surgeon. He regards the method of Morcelllement too tedious, excepting for the larger tumors. For tumors above four inches in size, he always operates from above, tying off the ovarian arteries in the usual manner, dissecting off the peritonæum posteriorly and anteriorly of the cervix, and tying the uterine arteries in the usual manner with catgut, and removing the entire cervix, in most cases leaving but a bare shaving of the anterior and posterior lips, to avoid injuring the vault of the vagina. The stump is covered with peritonæum. Catgut is the only ligature material used in the abdominal cavity.

## GLEANINGS.

---

**HEART DISTURBANCES IN DYSPEPSIA.**—Prof. Robin calls attention to the liability of gastric disturbances being associated with heart symptoms, for a long series of authors, from Lasègue to Huchard, have proved this. There may be palpitation, intermittent pulse, fainting attacks, and pseudo-anginose and dyspnœic seizures. These dyspnœic attacks of dyspeptics should not be confused with the so-called ptomainic attacks of Huchard, where either the vascular system or the kidneys are faulty. The essential character is diagnosed by the absolute integrity of the circulatory system. Various theories have been advocated, as pressure of the stomach on the heart, auto-intoxication, the action of the pneumogastric reflex, etc. In treatment, tobacco should be entirely discontinued. The same holds good for alcohol, tea, coffee and wine. The evening meal should be light, all meat and fish being avoided. Bread is best eaten very little, or left off, as it causes very distressing fermentation in the stomach.

It is a safe rule not to prescribe heart tonics to patients with dyspepsia. While exercise in heart subjects is dangerous in gastralgies, a short walk frequently acts as a sedative. The flatulency should be treated, as it alone will undoubtedly cause heart symptoms. If the symptoms persist, then the patient should leave off all work and go and reside in a quiet and well-aired location for a time. Moderate elevations of five to six hundred metres in the midst of forests are the best resorts in such cases.

In some cases which are particularly obstinate he has obtained good results with Oertel's method for the treatment of obesity. In all cases it is well to remember that the nervous system plays a very important part.—*La Settimana Medica*, No. 50, 1897.

**IODIDE OF POTASH AS A DIAGNOSTIC MEASURE IN PULMONARY TUBERCULOSIS.**—Several years ago Dr. Stiker, of the faculty of medicine of Geisen, Germany, announced that the iodide of potash, in a daily dose of seven and a half to fifteen grains, in cases of suspected pulmonary tuberculosis, would give rise to a local catarrh in the diseased part and increased expectoration, in which the characteristic bacilli would be detected. Dr. Vetlesen has also tried this method, administering to twenty-seven patients a 1.5 per cent. solution of the iodide, in doses of a teaspoonful three times a day. In eight subjects he had positive results, for in two or three days the expectoration increased, together with the cough, and auscultation revealed sonorous râles in different parts of the lungs where no pathological signs had as yet been noticed. In four of these patients the tubercle-bacilli could be discovered; in the others, other signs, as enlarged glands and tubercular osseous lesions, facilitated diagnosis. The other nineteen presented no reaction in the lungs, and he considered them as non-tuberculous. For, indeed, in none was either there bacilli in the sputa nor did tuberculin give a reaction. Therefore, he



recommends this measure to physicians who have not the means at hand for a bacteriological examination of the sputa.—*La Settimana Medica*, No 51, 1898.

Some years ago there was reported in a Russian journal the case of a healthy young woman who immediately developed tuberculosis of the lungs, which ran a rapid course, after taking the iodide of ammonia.

**A BOTTLE IN THE RECTUM.**—Dr. Delbet recently removed a bottle from the rectum of a subject where the foreign body had lodged in the sacrococcygeal curve. From this and two similar cases published in Normandy, he holds resection of the coccyx to be the method of choice in those cases where foreign bodies are lodged in and cannot be extracted from the rectum. Dr. Monod, of Paris, out of thirty-three cases of foreign bodies in the rectum, had six where a rectotomy was necessary.—*La France Médicale*, No. 52, 1897.

Several years ago I saw J. C. Warren extract a catchup bottle filled with catchup, and having a metallic cap, from the rectum of a simple-minded fellow, at the Massachusetts General Hospital. He had walked eighteen miles that morning from a near-lying country village into Boston. I think that Warren also resected the coccyx.

**LATE TERTIARY AND HEREDITARY SYPHILIS OF THE NASAL PASSAGES.**—Dr. W. Wróblewski finds late hereditary and tertiary syphilis to affect the nasal passages in half the cases where the upper respiratory passages are involved. The greater number of his cases, one hundred and twenty, were men between the ages of thirty and forty; in some cases it may be of hereditary origin. Diagnosis is particularly difficult, for it may appear as a unilateral purulent coryza, simulating that due to a foreign body or a suppuration of the antrum of Highmore; or, again, the turbinates may be covered with thick, pearly gray membranes, simulating those of croupous rhinitis or that consecutive to cauterization with the galvano-cautery. The subjective symptoms are absolutely those of a simple coryza, and only with the nasal sound and the speculum are indurated patches found which even after cocainization bleed easily. These are sometimes covered with ulcers, but, above all, the presence of denuded bone is an especial point in favor of syphilis. The prognosis, except in malignant cases, is favorable. Internally, one should employ the mixed treatment, and locally strive after scrupulous cleanliness by means of irrigation with solutions of boric acid, the bicarbonate of soda, the permanganate or the chlorate of potash. The ulcers should be cauterized with chromic acid, which he regards as a specific in rebellious syphilis of the upper respiratory passages. The sequestras should not be extracted until they are entirely loose, when an ordinary pair of forceps will suffice. Bloody operations are contraindicated.—*Przegląd Chirurgiczny*, tom. iii., Zeszyt 4, 1897.

**CAMPHOR AS AN ANTIGALACTAGOGUE.**—Prof. A. Herrgott (Nancy, France) has found camphor to be an excellent antigalactagogue in mothers who do not desire to nurse their children. He administers 20 cgms. (grs. iij) three times a day for three consecutive days. In thirty cases where he employed this remedy the lacteal secretion diminished in a remarkable manner.—*La Semaine Médicale*, No. 26, 1897.

This is frequently employed locally as spiritus camphoræ in Northern Ohio both in veterinary and in medical practice to suppress the secretion of milk. It is, in fact, an old German remedy.

Dr. F. Ratier—*Dictionnaire de Médecine et de Chirurgie Pratiques*, vol. iv., p. 420 (1830)—in his article on "Camphre," says: "Des praticiens recommandables conseillent le camphre à l'extérieur, dans les cas d'engorgement inflammatoires des mamelles, qui surviennent pendant l'allaitement, et qu'on désigne sous le nom de *poil*. D'après leur observations, un liniment composé de camphre et de jaune d'œuf diminue la douleur et favorise la résolution; ce se conçoit à merveille: ils disent même que ce médicament administre à l'intérieur, et mêlé avec le nitrate de potasse et l'acétate d'ammoniaque, diminue la sécrétion de lait."

FRANK H. PRITCHARD, M.D.

**TREATMENT OF GONORRHEA.**—Dr. Elmer Lee begins the treatment in all acute cases by the frequent application of pounded ice to the urethral side of the penis. A small rubber bag, similar to a condom, is partially filled with fine pieces of ice, and this is laid against the under surface of the penis and secured with a few turns of a broad bandage or binder. This ice poultice is to be adjusted at night before retiring, and allowed to remain until morning. When practicable, the ice bag should be applied both in the morning and again in the afternoon; but this is a matter which is to be determined in each case according to the circumstances. The chilling of the urethra is quite free from danger of harm to the patient, and after the first few moments the penis is benumbed so that the cold is not disagreeable, even though maintained for a long time. In taking cases of this kind, it is the invariable rule to arrange with the patient, at the first or second visit, for an agreed fee, without contingencies or defaults. The patient will cheerfully agree to a fee at the beginning of treatment which he would think excessive and decline to pay at the end of the case. It is right and proper that one-half the money should be paid at the start. The point is of great importance to secure full co-operation of the patient, and also to leave no room for financial disputes at the end.—*Medical Times*, February, 1898.

[This arrangement of a fixed fee, partly paid in advance, is an almost invariable rule among the advertising *specialists* of Philadelphia, and their success from a financial standpoint cannot be questioned.—F. W. B.]

**ABDOMINAL INCISIONS.**—Woolsey sums up an excellent article, in the January number of the *Annals of Surgery*, with the following conclusions:

1. Abdominal incisions, except those in or close to the median line, should be obliquely transverse in order to parallel the nerves (and thereby also the cleavage line of the skin) so as to avoid partial paralysis of the muscles, weakness of the abdominal wall and a tendency to hernia.

2. Intermuscular, or even transmuscular, incisions should be preferred to those in the linea alba or semilunaris, for in both the latter cases the cicatrix is less strong and more prone to hernia, and in the semilunar line the nerves are necessarily divided.

3. In place of the median vertical incision the intermuscular incision near the inner margin of the rectus, or the trap-door incision around the inner margin, offers many important advantages.

**NOURISHMENT DURING LABOR.**—Dr. Jane K. Culver, of Boston, notes: If there is one thing more than another which I think is indispensable in obstetrical work it is looking sharply after the nourishment. After a few hours of labor a woman is in the position of a laboring man, having used up much strength. If only she will take gruel, an egg-nog, or a little light food of some kind, she has something to work on, is not so exhausted, and has more courage. Even if she should not wish food, and vomits, the vomiting itself is often a great help.

F. W. BRIERLY, M.D.

**COLPOTOMY, AND THE SURGICAL TREATMENT OF PELVIC PERITONITIS.**—(A. Martin.) The steps in the operation are as follows:

1. Opening of the pelvic cavity.
2. The separation of adhesions and the isolation of the various organs within their natural boundaries.
3. The care of diseased portions of the various organs, especially the torn and injured peritonæum.
4. Closure of the peritonæal cavity, with especial reference to avoiding cicatricial tissue in the peritonæum.

So far as is practicable the peritonæum should be opened from the vagina.

Tumors of considerable size can be removed by such an incision; but in some cases of extensive pelvic peritonitis, it may be necessary to open the abdominal cavity from above, and especially where there is danger of injuring the bladder or the ureters, and where there is to be extensive separation of intestinal lesions. Separation of adhesions and isolation of the various organs within their natural boundaries is best accomplished by the finger, especially when the uterus is the chief mass in the pelvic organs. Sometimes the adhesions may be wiped away with a sponge or piece of gauze. It is surprising to see how much parenchymatous hæmorrhage may take place from such surfaces; but this can be controlled by the continuous suture.

My experiences are based upon 471 operations. Sixty cases were free from pelvic peritonitis, but had retroflexions which were cured. In the remaining 411 cases it was possible to cure more or less extensive pelvic peritonitis. Fifty-nine cases were complicated by larger or smaller myomas; 42 by serous sacro-salpingitis; 18 by purulent sacro-salpingitis; 5 by nodular salpingitis; 4 by tubal pregnancy; 26 by tubo-ovarian tumors; 25 by ovarian cysts; 7 by large hæmatomas of the follicle; 44 by dropsy of the follicle; 2 by parovarial cysts; 3 by intraligamentary cysts.

Four hundred and sixty-seven of these 471 very complicated cases were dismissed from my private hospital within an average of fifteen days after the operation, and only 31 showed a reaction of fever. Four patients out of the 471 died—2 from sepsis; 1 from ileus; and 1 from pneumonia, the twenty-first day after the operation. There were 6 per cent. of recurrences of the pelvic peritonitis. Six-seven per cent. were cured of chronic pelvic peritonitis. Twenty-seven per cent. of the patients, living under very unfavorable conditions were partially improved. Eighteen patients became pregnant.

**THE USE OF PHOSPHATE OF STRYCHNIA DURING GESTATION.**—(Dorsett.) He recommends the pills of Parke, Davis & Co., each containing  $\frac{1}{100}$  of a grain. A good appetite and a good assimilation are obtained in the general weakness and debility of the anæmic. Constipation is relieved, and the pa-



tient is built up and placed in a good condition to pass through the ordeal of labor. The uterus contracts firmly after the third stage, and the use of ergot is entirely dispensed with. If he finds it necessary to use the forceps, the patient is given a hypodermic injection of  $\frac{1}{30}$  of a grain of the sulphate or phosphate of strychnia as soon as the anæsthetic is commenced, but no ergot is ever used. He has also observed that after the continuous use of the phosphate of strychnia the uterus contracts firmly after the second stage of labor, and in many cases the application of Crede's method of expressing the placenta is not needed to bring it away, and no post-partum hæmorrhages have occurred.

GEORGE R. SOUTHWICK, M.D.

**DIABETIC RETINITIS.**—Oscar Dodd, M.D., Chicago, calls attention to the fact that "although the existence of diabetic retinitis has been known for a long time, the literature on the subject is very meagre and unsatisfactory.

He has tabulated the histories of forty-seven cases, all the cases of pure diabetic retinitis reported in literature, and from the study of these he has collected characteristics indicative of the disease.

In discussing the differential diagnoses he gives the table prepared by Badal:

*Diabetic Retinitis.*

1. Marked tendency to atrophy of optic nerve.
2. Multiple hæmorrhages round and disseminated.
3. Alterations diffuse.
4. Apoplexies do not last to a late stage.
5. Small disseminated spots with some exudate.
6. Color-sense, nil.

*Albuminuric Retinitis.*

1. Less tendency to atrophy, which occurs especially at a later stage.
2. Hæmorrhages equally multiple, but elongated, and occupy especially the posterior layers.
3. Affect principally the circum-papillary and muscular regions.
4. Last throughout life.
5. Whitish fatty spots with infiltrations.
6. Persists a long time.

—*Archives of Ophthalmology.*

**DISEASES OF THE EYE DEPENDENT ON EPIDEMIC INFLUENZA OR GRIP.**—The writer after mentioning the many diseases of the eye which have been attributed to the grip by various authors, says: After a careful review of this subject, I would state the following as my conclusions:

1. The eye affections following the grip are comparatively rare.
2. That many of the cases reported as being due to grip are fanciful, and need more substantial proof.
3. Grip may affect the eye by a direct inflammatory process, or by extension from the accessory sinuses.
4. It may affect the nerves of the eye.
5. It is especially liable to affect the conjunctiva, the uveal tract, and the tissues of the orbit, and, perhaps, the fibrous capsule.
6. In some of these cases the extension is by metastasis and in others by direct continuity.
7. Before attributing any eye complication to the grip, careful and thorough scrutiny is necessary to exclude other causes, such as syphilis, alcohol, etc.—*American Journal, of Ophthal.*—THOMAS POOLEY, M.D., New York.

WILLIAM SPENCER, M.D.

## MONTHLY RETROSPECT

### OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

---

**THE COUGHS OF RUMEX AND NUX VOM.**—According to Cowperthwait, *rumex crispus* is a remedy of great value in coughs accompanying acute catarrh of the larynx and bronchi, or from laryngo-tracheal irritation. The chief feature of the drug is that the cough is always produced by tickling in the throat-pit, and has invariably associated with it a raw sensation behind the sternum. Under such circumstances its effects are marvellous. The cough is generally incessant, fatiguing, and is aggravated by pressure, talking, and especially by inspiring cold air, and in the evening after lying down.

The author believes that *nux vomica* is not as often prescribed for coughs as it deserves. It is valuable in bronchial catarrh with a dry cough, and accompanied by roughness, rawness and scraping in the chest, thus reminding us of *rumex* but being less acute in character. Violent, dry, fatiguing cough, worse early in the morning. It is useful in reflex coughs arising from gastric troubles and mental exertion.—*N. A. Journal of Hom.*, January, 1898.

**THE TREATMENT OF IVY POISONING.**—Referring to a case in which crocus promptly cleared up the symptoms due to the suppression or incomplete cure of ivy poisoning by the combined use of alternated remedies, the *Medical Century* (February 1, 1898) suggests that it would appear from the description that it might have been better not to have resorted to the external measures. The writer long having been a sufferer from this form of dermatitis has tried everything in the category, from the mildest domestic lotions to strong solutions of nitrate of silver, and has learned from many annoying results to discard altogether the use of external agents and to rely wholly upon the most clearly indicated single homœopathic drug. In recent years the best results have been obtained from belladonna, cantharis, *rhus venenata* and *apis*; but the essential thought, no matter what the selected agent, is to give but one remedy at a time and trust wholly to allaying inflammation by the action of the remedy administered internally. Belladonna acts promptly in suitable cases, quickly allaying intense inflammation. Cantharis and *rhus venenata* have been found most beneficial for the intolerable itching, while cases characterized by edematous swelling, without great pain or itching, but with soreness or burning, are helped by *apis*. *Mercurius sublim.*, *sepia* and a few other remedies are occasionally indicated also. Large personal and professional experience has led to discarding all external applications except pure olive oil to protect the skin from air and moisture.

**THE INDICATIONS FOR GELSEMIUM.**—Hengstebeck, of Leipsic, sums up, as of greatest practical importance, the following indications:

1. Paralysis of the eyelid (sinking down of the upper lid).
2. Diplopia, paralysis of the muscles of the eyes (both caused by paralysis of the *nervus oculo-motorius*).

3. Paralysis after diphtheria.
4. Paralysis of the vocal ligaments (paralysis of the nervus laryngeus infer.).
5. Difficulty in deglutition (paralysis of the rami pharyngei of the nervus vagus).
6. Headache, extending from the neck over the head into the eye (similar to that of *cimicifuga*) with characteristic mental symptoms; at times megrim.
7. Diseases of the male and female sexual organs: impotence, incipient gonorrhœa, rigidity of the os uteri during parturition, menstrual troubles.
8. Professional ailments (professional neurosis, cramps from writing and from playing the violin).—*N. A. Journal of Hom.*

THE TREATMENT OF THE RHEUMATIC DIATHESIS.—In a discussion of the rheumatic diathesis and its treatment before the section in Pedology of the American Institute of Homœopathy, Geiser, of Cincinnati, laid particular stress upon the need of proper hygiene, including proper nutrition, the elimination of uric acid, and thorough protection of the body with woolen underwear. As to remedies, to restore the general tone and to increase the standard of the red-blood corpuscles, and to add to the resisting power of the tissues to disease, he proposes the use of *ferric phosphoricum*, *arsenicum*, *nux vomica* or *strychnine*. In pale, anæmic, sensitive subjects, *lycopodium* and *cuprum* will be of value, the former especially if the urine contains a lithic acid deposit. When there is a history of rheumatism or muscular pains with manifestations of chorea of the mother during pregnancy, or chorea in a child associated with myalgia or rheumatic ailments, *cimicifuga* will be indicated. In cases where characteristic urinary symptoms are present, *berberis* will be of incalculable value. Where dampness seems to be the exciting cause, *dulcamara*, *rhus tox.*, and *natrum carb.* will be called for.—*Medical Era*, 1897.

KREOSOTUM IN ECZEMA.—Dearborn, of New York, asserts that while carbolic acid is the chief principle in kreosote, there is difference enough in the pathogenesis of the two drugs to give each a distinct place as a remedy. Kreosote disorders the blood, produces an irritant effect on the mucous membranes and the skin, which may thus cause local or general disturbances of nutrition, derangement of function, or inflammation of the surface tissues. Through its action on the nerve centres a great variety of paresthetic sensations may be felt.

On the skin it produces functional derangement of the sebaceous and sweat glands, a tendency to ecchymoses (from slight causes), papules, vesicles, fissures, scales and crusts, persistent and unhealthy in character, sometimes degenerating into malignancy, with offensive secretions, and rarely a gangrenous tendency. Sensations indicating kreosote are more often described as burning, itching, biting, stiffness or tensive pain. The favorite locations for papular and scaly eruptions are the back of the hands, the face, ears, back and shoulders; for fissures, the hands and on or about the lips; while vesicles or wheals may occur at these points of selection or generally over the surface. The eruptions are worse, as a rule, at night in bed, from pressure of clothing, from friction, but may be relieved by scratching.

Papulo-squamous or papulo-vesicular eczema of the dorsal surface of the fingers and hands, sometimes excited by repeated contact with irritating sub-



stances (trade eczemas), and obstinate in course, frequently present enough indications for kreosote to make it a curative remedy. Moist eczemas of the face or ears, with offensive secretions, burning and itching pains, worse at night, may be cured with this drug.—*Chironium*, February 15, 1898.

ANTIMONIUM TARTARICUM AND GLYCOSURIA.—Mack, discussing the fatty degenerations of antimonium tartaricum, recalls the suggestion of Brunton that possibly there is connection between the fact that phosphorus, arsenic or antimony will cause fatty degeneration of the liver, and the fact that any one of these drugs will so destroy the glycogenic function of the liver that in animals poisoned by it puncture of the fourth ventricle will no longer cause glycosuria. He says that attempts have been made in the treatment of diabetes to utilize the power that any one of these drugs has of destroying the glycogenic function, but that, as yet, the results of these attempts have not been very satisfactory. The writer does not anticipate that further attempts will yield satisfactory results.—*Medical Century*, March 1, 1898.

THE INTESTINAL SYMPTOMS OF VERATRUM ALBUM.—Teal, of Omaha, recalls the fact that the characteristic symptoms of veratrum in these cases are the appearance of the stools, retching and vomiting, especially after food or drink; cramps in the abdomen or calves; cold sweat, especially on the forehead, and collapse. Camphor vies with veratrum here. It has coldness and collapse, but the cold sweat is not always present, and the discharge more scanty, with more pronounced nausea. Podophyllum is one of our sovereign remedies in acute intestinal troubles, but there is a notable absence of pain. Veratrum is not indicated unless there is evidence of suffering. Carbo veg. has the same collapsive condition but not the cramps of veratrum, and the breath is cool. Cinchona is indicated in a profuse watery diarrhœa, usually with undigested stools, which are painless. It is especially useful in long-lasting cases which have led to weakness and debility. Arsenicum stools are generally dark colored, offensive, excoriate the anus, and are worse after midnight; the arsenicum patient is also much more irritable and restless.—*Medical Era*, February, 1898.

THE THERAPEUTICS OF CHRONIC CYSTITIS.—Bruce, of Chicago, states that cantharis, apis, belladonna and ferrum phos., so useful in acute cystitis, have not aided much in the treatment of chronic cases. Chimaphilia, uva ursi, stigmata maidis, lycopus, saw palmetto, sandalwood, tritica repens, pulsatilla, berberis vul. and benzoic acid are, in his hands, the most useful in a therapeutic way, with boric acid, salol and beta naphthal in a chemical way. Saw palmetto and pulsatilla have been of most service in cases where the prostate was tender and enlarged. Tritica repens has, in several instances, given most satisfactory results in cases where the flow of urine started after some considerable delay and effort. Lycopus is useful in similar cases. Berberis is indicated when the urine is loaded with uric acid and the pain extends from bladder to kidneys. Benzoic acid is needed when there is inability to hold the urine, particularly at night, when the patient has been in bed for some hours. Boric acid, salol and beta-naphthal relieve pain and sterilize the urine.

The most careful internal medication alone does not accomplish much in a majority of suppurative cases. The bladder must be carefully washed out, and if the prostate is involved it also must be treated.—*Medical Century*, March, 1898.

F. MORTIMER LAWRENCE, M.D.

# THE HAHNEMANNIAN MONTHLY.

---

MAY, 1898.

---

## A REPORT OF TWO CASES OF TREPHINING FOR EPILEPSY.\*

BY SIDNEY F. WILCOX, M.D., NEW YORK.

Professor of the Principles of Surgery in the New York Homœopathic Medical College and Hospital.

I PRESENT the report of these cases to the Society as illustrating the severe symptoms which may follow comparatively slight injuries, or which occur as a result of what would seem to be an insignificant amount of thickening of the bone causing pressure upon the brain.

The first case, W. A. S., aged six years. At birth the confinement was severe and it was found necessary to use forceps, and a great deal of pressure had to be employed. The pressure was so great upon the sides of the head and the scalp so much damaged that the hair did not grow at this point until he was a year and a half old. When he was three years and nine months old slight twitches were noticed in the right cheek. These extended from the mouth to the eye. The child continued to grow worse and the twitches increased to spasms of the right side of the face, right arm and right leg. After nine months of treatment under some of the best physicians in

---

\* Read before the N. Y. Co Homœopathic Medical Society, March 10, 1898.  
VOL. XXXIII.—18

Brooklyn, the trouble, instead of improving, developed to such an extent that at times the spasms convulsed the whole body. These spasms were not of long duration, lasting only from a minute to a minute and a half. He also had frequent attacks of *petit mal*. These were always more numerous than the *grand mal*, reaching on an average about thirty per day. After a year of careful homœopathic treatment, it was found necessary to use bromide of potash, and under this he began at once to show signs of improvement. For six months he did not have a severe spasm, and the average number of attacks of *petit mal* was lowered from thirty-nine to thirty per day. At the end of eight months the *grand mal* again began to increase and the bromide to lose its effect.

The boy was sent to me by Dr. J. E. Russell, of Brooklyn, and at that time he was having an average of a thousand fits a month, and sometimes running as high as sixty-five in a single day. The case seemed to me rather hopeless, but upon the father asking if anything could be discovered by the X-ray, I referred him to Dr. William Harvey King for examination, who saw him on two occasions. Dr. King and Dr. Butler, of Brooklyn, consulted in regard to the case and came to the same conclusion, but reasoning from different premises. Dr. King, on examination, found dark spots in the skull which indicated a thickening of the bone over the location of the fissure of Rolando. Dr. Butler came to the conclusion that there must be pressure at this point, reasoning from the symptoms as manifested.

When I first saw the child there was marked muscular incoordination. He was becoming stupid, would answer only "Yes" or "No;" he was liable at any moment to have fits, and fall, and had to be watched constantly. He was never allowed for a second to be away from the care of some one for fear that he would suffer some injury. He had fallen repeatedly and struck his head against various objects and was in a most pitiable condition, and the parents were willing to take any possible chance for his improvement.

I did not offer a brilliant prospect, but told them that if they would assume the responsibility I would perform the operation of trephining. On the 18th of November last I operated upon the boy at the Hahnemann Hospital, removing a portion of



bone, approximately  $1\frac{1}{2}$  inches square, with the chisel and rongeur forceps. This was sufficiently large to take all pressure from any portion along the fissure of Rolando. Immediately, on raising the portion of bone, the bulging was very pronounced, and after incising the dura mater in order to still further relieve the pressure, the bulging of the brain was quite remarkable; the arachnoid and pia mater were not disturbed, as there was no indication of disease in the brain-substance. The portion of bone which was removed was thickened, being twice the ordinary thickness at the point where it covered the motor areas. The dura was brought together with catgut; the portion of the bone loosened up was entirely removed, and the scalp was placed back in position and stitched with silkworm-gut sutures. One or two small drainage tubes were placed in position and the wound dressed antiseptically.

There was nothing of any importance to relate during the time of convalescence at the hospital, where he remained for about two weeks after the operation. When he was discharged he was entirely healed and had had no spasms. He left the hospital on December 4th. Through not understanding the importance of quiet, some friends were allowed to see him after he had taken the journey back to Brooklyn, and on that night he had two spasms. The next night he had one more spasm, but I think these were due largely to the excitement of the journey and seeing an unusual number of people. Since that time, for the past three months, he has been entirely free from anything like a spasm. Since the operation, he does not have perfect co-ordination of muscles, his walking is not straight, he stammers and is erratic in his actions, but he has not had, since the second day after his return, any signs of spasm. He reads and talks well, and, for the time which has elapsed, certainly shows great signs of improvement.

CASE II.—Patient J. S., young girl, fourteen years of age. Eighteen months previous to my seeing her this patient fell and struck her head on the corner of a box. The point injured was about one and one-half inches upward and backward from the mastoid process. The accident was not considered severe enough at the time to call their physician, Dr. H. J. Pierron. But, later on, a peculiar train of symptoms presented themselves. The first noticed was that while walking

across the room, all at once she fell asleep, and sank to the floor. The sleep was accompanied by fearful dreams and visions, and the impression remained in her mind even after she was awake. There seemed to be no premonitory symptoms before the attack. For instance, one time she was walking with her mother, who had her arm around her. Suddenly the mother noticed that the child hung like a dead weight on her arm, and she found she was in a deep sleep. She became irritable, the attacks would vary in intensity and frequency at different times, and her face began to have a vacant expression. Last year, when she went in the country, the attacks grew much worse, and one or two physicians who saw her there were unable to diagnose the disease, but thought she would probably outgrow it. When she returned in the fall she was much worse, and Dr. Butler was called in consultation. One peculiar symptom was that at the point where she struck her head against the box there was always a painful spot; and no matter what attempt was made to deceive her or to make it appear that the pain arose from some other point, pressure on this one small point always elicited pain, and nowhere else. The symptoms were increasing in intensity, and Dr. Butler, being called in, diagnosed pressure on the brain at the point of injury. The case was not one of typical epilepsy, but the symptoms were so pronounced and the tendency to true epilepsy so evident that he advised operation. The operation performed was similar in character to the one in the first case, with the exception that the dura was not incised. The bulging was considerable, and the plate of bone which had been raised was removed entirely, and the edges of the opening in the bone smoothed off with the rongeur forceps.

The peculiar point about this case was that the bone was thickened for a space about as large as a nickel, directly under the point where the injury had occurred. There was no sign on the scalp of any external injury, but the bone, besides being thickened, showed the appearance of formation of new bone; and there is no doubt that the increase of bone was the result of the injury at this point. The thickening amounted to about three times the thickness of the surrounding skull. While this apparently would cause a very small amount of pressure, the fact that the patient has been entirely well since the operation indicates that there was sufficient pressure to cause the symptoms from which she had suffered.

Of course the time which has elapsed since either operation is far too short to form any final judgment as to the results; and it is well known that any operation will, in some cases, stop the fits for a time. Still, the results thus far, and the fact that actual thickened bone was found, give ample justification for the belief that the final results will be favorable.

---

## THERAPEUTICS OF OXALURIA.

BY CLIFFORD MITCHELL, M.D., CHICAGO.

WHATEVER may be the theories in regard to the existence or non-existence of oxaluria as a primary disease, the clinical fact remains that certain individuals are prone to a disorder in which a deposit of crystals of oxalate of lime in the freshly voided urine is associated with nervous or gastric symptoms, and sometimes both. I cannot agree with those who attribute the sediment wholly to the use of certain fruits or vegetables. Having had a case of oxaluria constantly under my observation for more than fifteen years, I can assert that even when vigorous abstinence from such articles of diet is observed the crystals may yet be found in the sediment. On the other hand, I do not deny that ingestion of such things as rhubarb, tomatoes, bananas and apples tends to increase the number of the crystals, and that oxaluria is more common during the "rhubarb-pie season." There are undoubtedly several classes of cases, as follows:

1. Cases in which nervous diseases, as melancholia, and other troubles, as diabetes mellitus, are attended by oxaluria, and in which disappearance of the sediment is not followed by relief of the other symptoms.

2. Cases in which nervous or gastric symptoms are attended by a sediment of oxalate, and in which disappearance of the sediment is followed by marked relief.

It follows, therefore, that therapeutic measures which shall cause the sediment to disappear are of importance in determining whether we have a primary or secondary disorder to deal with.



Very little information in regard to the therapeutics of oxaluria is at our command. The measures which I have taken in the treatment are as follows :

1. Prohibition of fruits and articles of diet generally which are rich in oxalic acid, and of sweets.
2. Use of distilled water as a drink.
3. Use of the cold-water compress over the abdomen at night, as advocated by Ralfe, for relieving abdominal catarrh.
4. Out-of-door life in dry climates whenever possible. Vacations to be taken on the plains or in the mountains of the West rather than at the sea-shore or near bodies of water.
5. Administration of remedies.

Among the few remedies which seem to exercise any control over the condition are oxalic acid, nitro-muriatic acid, and lysidine. Oxalic acid is given in potency for cases in which we find acid urine with a sediment of uric acid and calcium oxalate, attended by burning pain during micturition and pains in the region of the kidneys. No doubt other symptoms characteristic of this drug must be present, since these urinary ones alone are often observed in cases helped by other drugs.

Nitro-muriatic acid is of service in the case of young men with oxaluria and nervous symptoms, and is regarded as almost a specific in the cases apparently primary. It should be freshly prepared and given in doses of five to seven drops, three times a day, of the official *dilute acid*. Lysidine is a remedy of promise in oxaluria. I have used it recently in two cases with gratifying and, I admit, unexpected success. Lysidine is a modern substance of complex character, ethylene-ethenyl-diamine, occurring in red-white crystals. It is said to be innocuous, not disturbing digestion or circulation, and not irritating the kidneys. It is dispensed in 50 per cent. solution, the dose of which is ten minims, three times daily, well diluted in aerated water. The two cases in which I have used it were very different in character, one being a young man whose affection was comparatively recent, the other in an older man with a long-standing oxaluria. In the second case the distressing pain in the lumbar region was apparently relieved by a few doses of a few minims of the agent, after having persisted for a number of days. The second case is particularly worthy of mention, as various measures had failed to relieve the pain in the past, and also during the present attack.

THE CORRECTION OF INVETERATE HYSTERO-RECTO-VESICO-PTOSIS BY  
LAPAROTOMY, AND IMPLANTATION OF THE UTERUS WITHIN  
THE ABDOMINAL INCISION.

BY T. L. MACDONALD, M.D., WASHINGTON, D. C.

IN reporting a case, and in the description of an operation, the less said about "priority" and "newness" the less research and disputation devolves upon certain readers. As fairly representing the measures employed for the relief of the above conditions, the following may be quoted from one of our modern text-books on gynecology: "In complete chronic prolapse the following operations must be done as matter of routine. At the first sitting, curettage, trachelorrhaphy, Emmet's anterior colporrhaphy, and hysterorrhaphy. In three or four weeks either Hegar's colpo-perineorrhaphy or Emmet's perineorrhaphy should be done. The time intervening between the two operative procedures is occupied with attention to the dressings for the curetted uterus and the removal of the stitches. In old women who may not expect conception, the preferable procedure is extirpation of the organ, instead of the plastic operations."

It has seemed to me desirable to avoid the uncertainties of many of these measures, as well as the two "sittings" (sometimes required), and the prolonged operative and post-operative period. Hence the following case:

*History.*—Mrs. —, æt. 68, and mother of several children. She had always been well except as to pelvic distress, which has continued for the last twenty years. She says that for fifteen years the womb has been protruding, and that she was unable at any time to replace it, even by the aid of recumbency, pressure and bandage. Urination grew more and more frequent and painful, defecation more difficult, digestion more impaired, and two years ago she was compelled to enter a sanitarium in Philadelphia. She was willing, and expected, to be operated on, but received only palliative treatment for two months, and the protruding mass was still between the thighs when she left

the institution. She endured her distresses patiently till January, 1898, when I first saw her.

*Symptoms.*—She had constant dragging and “bearing-down” pains in the abdomen and pelvis, frequent desire to urinate and inability to void the urine without stooping or lying, and then only a few drops at a time. The urine was voided with much pain, was cloudy and offensive. This frequent urging prevented sleep. She had sharp, colic-like pains in the abdomen; defecation was difficult, distressing and unsatisfactory, there being no expulsive power. As expected, examination of the urine revealed pus corpuscles, epithelia, and 168 grs. of urea to the ounce. She was suffering to such an extent that she was anxious for an operation, even if it resulted fatally.

*Condition on Examination.*—Separation of the thighs dis



An Irreducible Hystero-recto-vesico-ptosis of Fifteen Years' Duration.

closed the extruded mass lying on the bed. It consisted of the bladder, bowel and uterus, the fundus of the latter apparently atrophied.

*Treatment.*—This consisted of ineffectual attempts at reduction in the knee-chest position, then recumbency in bed for a week, with free evacuation of the bowels. As before stated, the mass had not been reduced for fifteen years, and was still intractable. The intestines, however, from recumbency and depletion, had returned to the abdominal cavity, reducing the mass to about half its size. (See photograph.) At first I considered the usual operative measures: hysterectomy and plastic work. Then it occurred to me that it would be much simpler to implant the uterus high in the abdominal wall and thus obtain support for the relaxed pelvic floor, the bladder and bowel. The patient was therefore prepared for an abdominal section,



in the usual way, at her own home. She was anaesthetized, placed in the lithotomy position, and the mass pushed within the vagina. The hands were resterilized, and an incision about two and one-half inches long carried through the abdominal wall, exposing muscular structures. A nurse then grasped the cervix, and, by introducing the hand and forearm within the vagina, pushed the fundus out through the abdominal wound. Here it was turned somewhat, so that its antero-posterior surfaces were in contact with the sides of the incision, and pressed and maintained in the upper angle of the wound. A half-dozen silkworm sutures were introduced through the abdominal wall, then deeply through the muscular wall of the uterus, and outward through the abdominal wall on the opposite side. Then the incision was closed, layer by layer, and with a few supportive "through and through" silkworm sutures. A small area of the fundus protruded between the lips of the wound and was left to cutify. Only a brief period was occupied with this work. The vagina was then inspected, and found widely distended and sufficiently patulous to easily admit a tea-cup; and although the bladder and rectum were drawn tautly upward, a few minutes more were devoted to the performance of an anterior and posterior colporrhaphy, and the patient placed in bed. There was no shock. The recovery was eventless, the bladder and bowel showing almost immediate improvement. The silkworm sutures were left in place for three weeks. The cervix is high, and can scarcely be reached by the examining finger; the fundus can be felt, firmly imbedded in the abdominal wall. The patient is so well that she is a constant surprise to herself. The bladder and bowels act normally.

*Comments.*—The production of adhesions between the fundus uteri and the parietal peritonæum, just above the pubis, for retroversion is familiar; but it would have been of little service in this case, as the bladder and bowels would still have protruded—such was the degree of pelvic relaxation. Shortening the round ligaments would have been useless: first, because this procedure would not have raised the uterus high enough "to take the slack" out of the vaginal walls; and second, because this means of support (even when combined with colporrhaphies) would not have been strong enough to sustain the weight of the protruding organs and overlying viscera, not to

speak of the intra-abdominal pressure. Colporrhaphies would have been inadequate and only temporary. La Fort's operation of closing the vagina is open to the same objections, and, what is equally important, neither of these operations would have taken the "kinks" out of the bladder and bowel and drawn them into place.

Hysterectomy is so easy and tempting in such cases that the operator has to hold himself back. But, after all, the uterus is not responsible for the ptosis, and hence its removal (without other operative steps) will not be curative. Why not, then, preserve it to support the bladder and rectum; in a word, to make it perform the function of a mesentery for the pelvic floor? True, it might be urged that the implantation of the uterus within the abdominal wall might lead to subsequent ventral hernia. This will scarcely be a very weighty objection in cases like the above—old women who have, at best, but a few years to live, who can wear an abdominal support without trouble, who are not subjected to the straining and exertion which circumstances may have demanded in early life; and finally, it is among women of advanced age that inveterate and intractable prostatic hypertrophy is usually found.

---

#### PHLYCTENULAR OPHTHALMIA.

BY W. H. LYLE, M.D., PHILADELPHIA.

(Read before the Trousseau Clinical Club.)

THE statistics of eye diseases show that phlyctenular ophthalmia makes up about 10 per cent. of such cases. It is an extremely common disease of childhood, and consequently one which the young practitioner is almost certain to be called upon to treat. Improper treatment—and by this I mean not only improper treatment of the attack, but failure to properly follow up that treatment during the interim—may mean the formation of corneal opacities and permanent loss of vision.

The pathology of the disease consists of a slight sub-epithelial exudation, composed of transparent fluid containing a

few leucocytes. The phlyctenules present themselves as slight elevations of a rosy or pink color, commonly called vesicles or pimples, on the conjunctiva or cornea, or both.

There are many causes. The most important is poor hygiene, with improper food, such as sweets, pastry, etc., and improper time of feeding. At times the disease follows scarlet fever and measles. It is often due to refractive errors, to diseases of the nose and throat, especially adenoids, and, in fact, the slightest irritation may cause a crop of phlyctenules to appear. At times this disease will be found in children who are fat and rosy, but it is very seldom that a careful examination fails to reveal some other morbid condition besides these phlyctenules upon the eye. If you look closely at the general appearance of the patient you will find the delicate white skin, the excoriations about the ears and nose, the enlargement of the cervical glands, the skin eruptions, and, in short, a typical picture of what we call the scrofulous diathesis.

The vascularity which these phlyctenules induce, and the loss of substance which they cause, give a general cloudiness to the whole cornea, and mark it with innumerable small macula, so that the victims of this unfortunate condition are reduced to little more than a bare perception of light.

The symptoms depend upon the position of the phlyctenules. If they occur upon the conjunctiva, we find the characteristic superficial triangular injection at the apex of which the phlyctenule is located; the surrounding ocular conjunctiva may show very little change. If you evert the lids, you will see that the palpebral conjunctiva is thick, soft and red, with slight discharge. There may be only one or many phlyctenules, which may be absorbed, leaving not the slightest trace behind, or they may break down, forming small ulcers, which heal very quickly. If the phlyctenules form on the cornea, you will find pericorneal injection, marked photophobia, lachrymation, more or less pain and smarting, and blepharospasm. These phlyctenules break down, forming small ulcers that may take weeks in healing, and leaving dense scar tissue behind. If this happens to be in the central part of the cornea, they will interfere very much with the vision, or they may perforate the cornea, forming anterior staphylomata.

The prognosis depends upon the course and extent of the dis-



ease. If due to the scrofulous conditions, recurrence of the attack, with partial loss of vision, may be expected.

The treatment of these cases is very important, and, no matter how poor the patient, by following the proper course good results can be secured. Strict attention should be paid to general hygiene. If the child is of sufficient age, the eyes may be protected with smoked glasses, and, under all circumstances, the patient should be encouraged not to bury his head in the bedclothing nor hide in dark corners, but should be made to go out of doors in all weather, to take exercise, and frequent sponge-baths with salt and water. Regulate the bowels. If the phlyctenules are upon the cornea, with considerable photophobia and pericorneal injection, a few drops of scopolamine solution, instilled into the eye at night, is useful to rest the eyes, and should be used as long as there is irritation. If there is much discharge, boric acid drops (gr. x. to ounce) should be used several times daily. Bathing the eyes in warm water is very beneficial, especially for removing the scales which form on the edges of the lids. After the irritation has subsided, finely powdered calomel may be dusted into the eye, provided the patient is not receiving potassium iodide internally. At times the local application of yellow oxide of mercury (gr. ss. to gr. i. to drachm of vaseline), a lump about the size of a pin-head, placed on the inner lid, is often beneficial. The extreme photophobia in some cases makes it difficult to properly apply the local remedies. For this reason the child's head should be taken between the knees, while the mother or an assistant holds the hands and body. The lids are then separated, and the cornea can be gradually coaxed into view. A lid elevator may be employed in very bad cases. Cocaine will temporarily relieve the photophobia, but should not be used as a constant application. I think that the most important part of the treatment, and this I want to emphasize, is the keeping up of the treatment with constitutional remedies between the attacks, as recurrence is very common.

Among the remedies which clinical experience has proven to be useful I would mention the following:

*Calcareo carb.* is useful for the fat, flabby child with large head and distended abdomen, pale skin, cold sweat about the head, skin eruptions and glandular enlargements. It is particularly useful when the child has been exposed to wet weather.

*Arsen. iod.* is good in superficial ulcerations, with intense photophobia and a profuse lachrymation, which causes burning and excoriation of the lids and *alæ nasi*. The conjunctiva is very much inflamed, often with chemosis. In general the patient is profoundly anæmic, and suffers from great restlessness and thirst.

*Aurum met.* is valuable in the treatment of scrofulous ophthalmia with ulceration and vascularity of the cornea; photophobia, lachrymation, irritability and sensitiveness to noise, and especially to light, with at times severe pain.

*Graphites* is one of the best remedies in both keratitis and conjunctivitis, either acute or chronic. As a rule there is blepharitis, the edges of the lids are covered with scabs, the external canthi are cracked and bleed easily, and the discharge is thin and excoriating, as is that from the nose.

*Merc. corr.* is prescribed by both schools of medicine, and is the most useful remedy when the phlyctenules break down and form ulcers on the cornea. The more severe the inflammation and pain, the more it is indicated. It is particularly indicated by a discharge which causes general excoriation, with pain that is aggravated at night and in damp weather.

*Hepar sulph.* is useful in the pustular inflammation after ulceration has commenced. The pains are very severe, of a throbbing, stinging character, ameliorated by warmth. The lids are red, even chemosed, and very sensitive to touch. *Hepar* is particularly indicated in cross children who have boils and skin eruptions.

In *pulsatilla* we generally find the mild, tearful disposition and the bland discharges from both eyes and nose, and at times from the ears. Cold applications and open air relieve. It is more useful in the conjunctival variety.

The sphere of action of *sulphur* is very wide. It is adapted to a wide variety of cases, especially the chronic cases with characteristic aggravation from 1 to 3 A.M. The pain is generally sharp and shooting in character, with a sensation as of a splinter in the eye, together with burning and smarting. The lids are agglutinated on awaking in the morning, and we usually find an eruption around the lids and on the body. The symptoms are worse in the open air and from washing the eye.

*Rhus tox.* is useful in the rheumatic variety, with superficial

ulceration of the cornea. Intense photophobia and lachrymation are characteristic of this drug. The upper lids are usually œdematous, the child is restless, and the symptoms are all worse at night and in damp weather. Especially useful in scrofulous ophthalmia.

*Chin. ars.* is frequently demanded by malarial conditions.

The general health may at times be much improved by the use of syrup of hydriodic acid or cod-liver oil.

In my own cases I invariably use scopolamine hydrobromate,  $\frac{1}{10}$  of 1 per cent. solution, in preference to the traditional atropine sulphate. I think that the indiscriminate use of atropine in eye work by the general practitioner does harm, and that preference should generally be given to the safer and more reliable scopolamine, which acts more quickly, and whose use is free from the undesirable and frequently dangerous effects of the better-known drug.

---

#### THE HYGIENE OF THE MIDDLETOWN STATE HOMŒOPATHIC HOSPITAL.

BY MAURICE C. ASHLEY, M.D., MIDDLETOWN, N. Y.

Assistant Physician Middletown State Homœopathic Hospital.

THE hygiene of an institution where the sick are cared for is a subject of much importance, but nowhere is it a matter for closer attention and more careful consideration than it is in our large State hospitals for the insane. Constant and never-flagging efforts on the part of each and every one who has to do with the management of such institutions is necessary in order that there may be maintained a standard of hygiene not incompatible with health. With all the modern means of ventilation, sterilization and disinfection, at first thought it might appear to be a small matter to keep a hospital up to a very high hygienic standard, but such is not the case. It is not the intention of the writer of this article to attempt to give more than a brief description and general idea as to what the sanitary condition is at the Middletown State Homœopathic Hospital, and tell a little something about how it is accomplished and maintained.



To my personal knowledge for the past eleven years there has not been an epidemic of any contagious or infectious disease at this hospital, and I am assured by those who know that an epidemic of any character has been successfully resisted for the past twenty-four years, or since the hospital was established, with but one possible exception, that during the erection of a new building fifteen years ago. There were a few cases of malaria, which were quickly stamped out after the newly-upturned soil had been sprinkled with a solution of copperas. Hence we think we are justified in feeling gratified and believing that our methods of resisting the invasion of micro-organisms is at least serviceable.

*Hospital Sites.*—Much care is and should be exercised in the selection of a hospital site, the construction of its buildings, material used, lighting, heating, ventilation, water-supply, and the disposal of its sewerage. These are all questions for the most careful consideration, but it is not our intention to go deeply into this subject. Suffice it to say, in this connection, that this hospital is located on the top of a hill about 700 feet above the sea-level. The soil is a mixture of stone and clay, with some sand, and affords very fair natural drainage. The buildings are two, three and four stories in height. The foundations are of native stones; the walls are of red, pressed brick, with sandstone and granite trimmings. The roofs are of black and red slate; ceilings are steel, and are all ten or more feet in height. The floors of the wards are either oak or hard pine. The interior walls are finished with a coat of plaster-of-Paris, and are nearly all painted. Every ward and room is well provided with windows and doors. The basements are light, dry and well ventilated. They have steel ceilings, stone and cement floors. All walls and supports which are not painted are kept constantly coated with lime whitewash, such as is used by the United States Government. The basements are kept almost entirely free from vegetable matter of any kind, thus preventing the possibility of the air which passes through the ventilators and steam-pipe coils from becoming contaminated before it enters the wards.

*Water-Supply.*—Our water-supply is from two sources: from deep wells and reservoirs. The latter are two and three miles distant from the hospital, and are about 100 feet above the hos-

pital grounds. The deep wells are near the hospital, and they are 600 and 800 feet in depth respectively. This water is used for general purposes about the institution. That used for drinking purposes is from several small wells on the hospital farm. Frequent chemical examinations of this water have been made, and it has always been found quite free from organic material. I believe, however, that all water used for drinking purposes should at least be filtered, and if the wells are in thickly-populated districts, or in the vicinity of large sewers, the water should be boiled before it is used.

The sewers are constructed according to the best plans, and have a fall of about two and a half inches to the hundred feet, and serve their purpose satisfactorily. Some years ago, for the purpose of economy, a system of tile-pipes was put in for subsurface irrigation. While this system carries off the liquid matter it does not dispose of the solid or semi-solid particles, the liquid being needed to dissolve and hold in suspension the solid matter in the large or main sewers, and leaves a doubt as to the utility of the subsurface system of sewage disposal. Hence the use of this system has long been discontinued.

Assuming that the minor details of the construction of the buildings are as they should be, we are prepared to look into the question of care of the buildings and the population of fifteen hundred people, twelve hundred of whom are mentally and physically sick. Many of the patients are extremely uncleanly in their personal habits, soiling themselves and their clothing, the beds, the floors, and about everything within reach, from one to a dozen times a day. They require frequent baths, and all are required to bathe, or are given baths, at least once each week. Some require a bath daily, and others have to be bathed several times during the twenty-four hours. The bath-rooms are mostly in towers built adjoining the wards. The wainscoting of these rooms is of marble or cement, six feet high. The floors are marble, slate or tile, and in nearly every ward of the hospital there is a spray-bath, as well as the tub. We do not limit ourselves to any particular kind of bath, but use any form which occasion seems to demand. As a whole, however, we much prefer the spray-bath, since it is more cleanly, economical, and less liable to the danger of the patient being scalded, and makes it impossible for more than one patient to be bathed in the same water.

The water-closets are all automatic, and flush with three gallons of water. A constant flow of water is maintained in the urinals. The plumbing, so far as possible, is exposed, and all pipes leading to sewers are ventilated above the roof. The existing methods of ventilating the closets and bath-rooms in hospitals is somewhat defective, inasmuch as the fresh air is only admitted through the windows several feet above the level of the floor, and does not find its way to the floor, coming in at one window and passing out of the opposite one, leaving the foul and noxious gases undisturbed.

*Laundry.*—This is an important factor in connection with any hospital, and especially so to a hospital for the insane. Here we have a laundry well equipped with most of the modern machinery, which has a capacity of, and is laundering, 33,000 pieces each week. All clothing, or any article soiled with the discharges from the body, or which have been used by or for a person suffering from any specific or contagious disease, is disinfected and sterilized before being laundered. Every piece of bedding, clothing or linen is removed from the ward, and sent to the laundry as soon as it becomes soiled.

All the slate or tile floors of the lavatories are scalded and scrubbed daily with carbolized soap. The floors of the entire hospital are wiped up or scrubbed every morning, and as much oftener as occasion requires. Every room is swept at least once each week, and dusted daily with a damp cloth. Several times a year all the walls are thoroughly washed with carbolized soap and water. The carpets are taken up at least twice each year, and thoroughly renovated and cleaned. The rugs, mattresses and pillows are frequently carried out into the sun, cleaned and aired. All wards and rooms about the institution are ventilated with much care, day and night, by both natural and artificial means. Electric lights are in use, instead of gas, and by this means much oxygen is saved for the inhabitants, and this is a matter of no small importance where twelve hundred sick people are constantly housed, and especially so during the winter months.

When a room has been occupied by a person suffering from any form of contagious disease it is not again occupied after it has been vacated until it has been thoroughly disinfected and repainted.



*Inspections.*—A systematic inspection of the entire hospital grounds and outbuildings is made at least once each week by one or more of the medical officers of the hospital. The wards, the kitchen, the bakery, the dairy, the laundry, barns, and, in fact, every part of the entire plant is critically examined. The wards, kitchen, dining-rooms, and the food-supply are inspected from once to several times a day, and frequent visits are made to all departments at night. A report of the sanitary condition of these several places is made at noon each day by the chiefs of departments to the superintendent, with such recommendations as may seem best. Much care is necessary, and is exercised, in the selection, purchase and preparation of the food-supply.

The milk, which is an important part of the hospital diet, is most carefully examined. The stables are kept as clean as possible, and are frequently lime-whitewashed. The cows' udders are washed before milking; and we believe, in this connection, that every dairy furnishing milk to a hospital should be inspected at least every two weeks, at regular and irregular intervals, by one of the officers of the hospital. The milk should be and is carefully strained and quickly reduced by ice to a temperature of about 45° F. All vessels used for milking are thoroughly cleaned with soap and boiling water, scalded, and then placed in the sun for several hours, for in no other way can they be kept sweet and clean. Milk should be sterilized by being heated to 168° F. before it is consumed, and should be kept in an ice-chest used for that purpose only. Other articles of food should not be placed in the same ice-box. The specific gravity of milk should not be lower than 1031 at 40° F.

*Employees.*—In a hospital where there are several hundred employees much care has to be exercised to guard against the introduction of contagious diseases. Many of the employees have families or friends near the hospital, or in the city, and sleep at home, and they are always liable to come in contact with people suffering from some form of contagious or infectious disease. When an employee has such diseases in his family he is not permitted to go home, or, if he does do so, he is not allowed to return to the hospital for one month, or until the period of danger of infection has been passed, and the employee has been thoroughly disinfected, and presents a certifi-

cate from his physician to the above effect. Employees should not be permitted to wear their uniforms away from the hospital for the same reasons.

*New Clothing.*—Much credit is due the State Commission in Lunacy for the rules promulgated by them regarding new clothing to be provided patients before they are admitted to a State hospital. This requirement enables us to keep out many forms of disease, besides the numerous kinds of vermin so frequently found in old and soiled clothing.

*Disinfectants.*—A disinfectant is any substance capable of destroying the infecting-power of any infectious material, and any substance which will not do this is not a disinfectant, and is useless for the purpose. Many substances have been placed on the market as disinfectants. Some are good and some are worthless. The American Public Health Association have made exhaustive investigations of many of the so-called disinfectants, and, together with the results, have published the following conclusions and recommendations, which I fully endorse :

The most useful agents for the destruction of spore-containing infectious material are :

1. Fire. Complete destruction by burning.
2. Steam under pressure.  $105^{\circ}$  C. ( $221^{\circ}$  Fahr.) for ten minutes.
3. Boiling in water for half an hour.
4. Chloride of lime 1. A 4-per-cent. solution.
5. Mercuric chloride. A solution of 1 : 500.

For the destruction of infectious material which owes its infecting-power to the presence of micro-organisms not containing spores, the committee recommend :

1. Fire. Complete destruction by burning.
2. Boiling in water for ten minutes.
3. Dry heat.  $110^{\circ}$  C. ( $230^{\circ}$  Fahr.) for two hours.
4. Chloride of lime. A 2-per-cent. solution.
5. Solution of chlorinated soda 2. A 10-per-cent. solution.
6. Mercuric chloride. A solution of 1 : 2000.
7. Carbolic acid. A 5-per-cent. solution.
8. Sulphate of copper. A 5-per-cent. solution.
9. Chloride of zinc. A 10-per-cent. solution.
10. Sulphur dioxide. Exposure for twelve hours to an atmosphere containing at least four volumes per cent. of this gas in presence of moisture.

The committee make the following recommendations with reference to the practical application of these agents for disinfecting purposes :

## FOR EXCRETA.

(a) In the sick-room :

1. Chloride of lime in solution, 4 per cent.

In the absence of spores :

2. Carbolic acid in solution, 5 per cent.
3. Sulphate of copper in solution, 5 per cent.

(b) In privy vaults :

1. Mercuric chloride in solution, 1 : 500 4.
2. Carbolic acid in solution, 5 per cent.

*Notes :*

1. Should contain at least 25 per cent. of available chlorine.
  2. Should contain at least 3 per cent. of available chlorine.
  3. This will require the combustion of between three and four pounds of sulphur for every 1000 cubic feet of air-space.
  4. The addition of an equal quantity of potassium permanganate as a deodorant, and to give color to the solution, is to be recommended.
- (c) For the disinfection and the deodorization of the surface of masses of organic material in privy-vaults, etc. :  
Chlorine of lime in powder.

## FOR CLOTHING, BEDDING, ETC.

(a) Soiled under-clothing, bed-linen, etc. :

1. Destruction by fire, if of little value.
2. Boiling for at least half an hour.
3. Immersion in a solution of mercuric chloride of the strength of 1 : 2000 for four hours.
4. Immersion in a 2-per-cent. solution of carbolic acid for four hours.

(b) Outer garments of wool or silk, and similar articles, which would be injured by immersion in boiling water or in a disinfecting solution :

1. Exposure in a suitable apparatus to a current of steam for ten minutes.
2. Exposure to dry heat at a temperature of 110° C. (230° Fahr.) for two hours.

(c) Mattresses and blankets soiled by the discharges of the sick :

1. Destruction by fire.
2. Exposure to superheated steam, 105° C. (221° Fahr.) for ten minutes.

(Mattresses to have the cover removed or freely opened.)

3. Immersion in boiling water for half an hour.



## FURNITURE AND ARTICLES OF WOOD, LEATHER AND PORCELAIN.

Washing, several times repeated, with :

1. Solution of carbolic acid, 2 per cent.

## FOR THE PERSON.

The hands and general surface of the body of attendants of the sick, and of convalescents, should be washed with :

1. Solution of chlorinated soda diluted with nine parts of water, 1 : 10.
2. Carbolic acid, 2-per-cent. solution.
3. Mercuric chloride, 1 : 1000.

## FOR THE DEAD.

Envelop the body in a sheet thoroughly saturated with :

1. Chloride of lime in solution, 4 per cent.
2. Mercuric chloride in solution, 1 : 500.
3. Carbolic acid in solution, 5 per cent.

## FOR THE SICK-ROOM AND HOSPITAL-WARDS.

(a) While occupied, wash all surfaces with :

1. Mercuric chloride in solution, 1 : 1000.
2. Carbolic acid in solution, 2 per cent.

(b) When vacated, fumigate with sulphur dioxide for twelve hours, burning at least three pounds of sulphur for every 1000 cubic feet of air-space in the room: then wash all surfaces with one of the above-mentioned disinfecting solutions, and afterwards with soap and hot water; finally, throw open doors and windows, and ventilate freely.

---

PERTUSSIS.

BY W. A. WEAVER, M.D., PHILADELPHIA.

(Read before the Trousseau Clinical Club.)

PERTUSSIS is a highly infectious disease, common to childhood, characterized by a number of short spasmodic expiratory coughs followed by a prolonged inspiration, accompanied by the pathognomonic symptom, "the whoop." It is more prevalent during the spring and winter months, occurring usually in epidemics, and frequently precedes or follows an attack of scarlet fever or measles. Pertussis is not confined to the young:

adults who have not been rendered immune by a previous attack at times contract this disease.

*Ætiology.*—The exciting cause is a micro-organism, a short bacillum, which has not with absolute certainty been isolated, yet cultures have been made, and inoculations into the trachea of animals have produced catarrhal conditions similar to those found in pertussis.

The predisposing causes to an attack of whooping-cough are : youth, climate, general debility from some constitutional disease, and a catarrhal condition of the respiratory tract which lowers the vitality of the lining mucous membrane and renders it more susceptible to the disease germs.

The mucus which is so freely secreted during the paroxysms is the contagium-bearer, and when drying upon the clothing or any other object, these organisms are liberated and are freely disseminated through the atmosphere, where they may shortly be inhaled, thus finding their way to the susceptible mucous membrane.

*Pathology.*—There is no pathology peculiar to pertussis. In the paroxysmal stage there is extreme congestion of the different organs, as the meninges, lungs, kidneys, and the heart. The morbid conditions found after death are those of the complications, as in pneumonia and in mechanical accidents, as hæmorrhage in the eyes, ears, meninges or other organs, and in vesicular or intestinal emphysema.

*Symptoms.*—There are three distinct stages in this disease.

*First.*—The catarrhal, lasting two weeks or a little more.

*Second.*—The paroxysmal, lasting from four to six weeks.

*Third.*—The convalescent or period of decline, lasting four weeks or more. The entire course of the disease occupying a period of ten to twelve weeks or longer.

*The Catarrhal Stage.*—This is preceded by a period of incubation varying from nine to fourteen days. The catarrhal symptoms then appear. These do not differ from any other acute inflammation of the respiratory tract, having the usual coryza, injection of conjunctivæ, dry cough and slight fever. The cough does not attract special attention early in the attack unless the parent has knowledge of the infection. It will soon be noticeable, however, that the cough is gradually growing worse, and that it occurs “in spells” which become more

marked until the whoop characteristic of this disease appears, usually toward the close of the second week.

The *second* or paroxysmal stage is therefore diagnostic of whooping-cough. The attacks vary greatly in length, severity and frequency in those affected. This stage is unattended by fever. On examining the chest during a paroxysm, percussion reveals a lessening of the pulmonary resonance during the expiratory effort, but a clear note during inspiration. The normal auscultatory signs are present during the attack, but a few râles may be heard directly following it. These paroxysms may be excited by most of the reflex acts, the more common being laughter and crying. There are a number of short continuous expiratory coughs, accompanied by a spasm of the glottis, preventing inhalation, then a relaxation of the spasm, followed by a long-drawn inspiration, and, because of the narrowed entrance into the trachea, the peculiar sound called the whoop is produced. These attacks gradually increase in severity until the eyes seem to protrude from the head, the mouth stands wide open in the effort to breathe, the face and mucous membranes become cyanotic, the conjunctivæ greatly injected, and death from asphyxia would seem inevitable. Accompanying the paroxysm there is usually a free discharge of thick tenacious mucus from the mouth, and frequently ending with vomiting of the entire contents of the stomach. Older children resist the paroxysm as long as possible only to have them occur later with increased severity. They are probably most severe in adults, who grasp any near-by object for support, and the effort to inhale, after partial relaxation of the spasm, causes so marked a whoop that it can be heard at a distance of several squares. In mild cases there may be only a half dozen paroxysms in twenty-four hours, but in the severer forms as many as sixty are recorded as having occurred in the same time. The oftener they occur the greater the exhaustion and emaciation and the more serious the interference with digestion.

The *convalescent* period is marked by less frequency of attacks, lessened severity, and finally entire subsidence of the symptoms. The least exposure to damp or cold may for a time re-excite the paroxysms, due to an irritation of the sensitive mucous membrane, and not a re-infection, as some writers claim. A "habit cough" may be formed, lasting quite a time after all the other symptoms have disappeared.



*Complications.*—These add gravity to each case, especially if they occur in constitutionally weakened children whose resisting and recuperative powers are small.

The most frequent, probably, is the ulcer upon the frænum of the tongue, due to forcible contact with the teeth during a paroxysm. Bronchitis is a more serious complication. Hæmorrhage from the mouth, nose, or in the eyes or meninges, is the cause of many of the sudden deaths from pertussis. Convulsions, emphysema, pleurisy, broncho-pneumonia and tuberculosis are serious complications or sequelæ, and call for special treatment.

*Diagnosis.*—The diagnosis, to which I have already referred, can only be made with a certainty in the second stage. The character of the cough, the appearance during an attack, the history of infection, and lastly the whoop, all unmistakably disclose the nature of the disease and make clear the diagnosis.

*Prognosis.*—When pertussis is complicated it becomes one of the most fatal diseases in early life. It is extremely so in young infants, particularly if complicated with a severe bronchitis or a broncho-pneumonia. It is also very serious in older children if they are debilitated or not cared for properly. Notwithstanding the enormous number of children who contract this disease and recover from it, many without medical aid, it is not as harmless as people suppose, when the deaths resulting from pertussis are third in the list of the fatal diseases occurring in childhood.

The common practice of mothers in certain localities, particularly country districts, of taking children to a neighboring household, without regard to their physical condition, where the children are known to have whooping-cough, that they may contract it in childhood, thinking it less severe and less serious than in older life, should therefore be most vigorously opposed by physicians.

*Treatment.*—It is a fact, notwithstanding the claims of many to the contrary, that treatment of pertussis in any form is only palliative, diminishing the frequency and severity of the attacks. Knowing the seriousness of this affection, the subject of isolation should have as much consideration as an attack of measles, follicular tonsilitis, and possibly as much as scarlet fever. Should a member of a family in which there is a very small or

delicate child contract pertussis, it is the duty of the physician or mother to isolate the child affected, and allow no communication between the different apartments by members of the family, as the contagium can be carried by the second or third individual. The heart and circulatory system suffer greatly during the progress of the disease. The alimentary tract very soon becomes affected, thereby interfering with nutrition, and the child's general health rapidly declines. It loses in weight, becomes emaciated, and has a cyanotic appearance even when not in a paroxysm. The first requisite, therefore, that demands attention, is to maintain the strength of the child. It is essential that the child be well fed by the frequent administration of small quantities of nourishing food. If vomiting occurs, the nourishment should be given directly after the paroxysm, that a greater amount may be assimilated before the recurrence of a similar attack. Upon the amount of food retained and digested depends the successful termination of the case. Children from six to twelve months old, fed upon milk, should retain 20 to 25 ounces in twenty-four hours. If the quantity ingested be much below this amount, the condition is very unfavorable. Stimulants very frequently are indicated if the vomiting persists and the patient is very much weakened. Oxygen is also an important agent in the successful treatment of this disease. With small children, during the winter months, two rooms should be employed, each heated to the same degree of temperature, one being oxygenated while the second room is occupied, thus alternately occupying and ventilating the rooms. Older children may be allowed in the open air the greater part of the day, provided the parents exercise the proper precautions as regards dress. Oxygen from a cylinder may be administered immediately following a paroxysm.

Prof. Bigler recommends eucalyptus oil spread over the crib at night to prevent attacks, also the vapor of cresoline in the room for the same purpose.

The mother can materially assist the child during a paroxysm by bending the body slightly forward, and also by removing from the mouth and nose the tough viscid mucus as it is dislodged, thus allowing free access of air upon the relaxation of the glottis.

*Remedies.*—There are no specifics for the treatment of this

disease, to my knowledge, but the distressing symptoms can be greatly ameliorated by internal medication. Each case must be individualized for the selection of the similimum. There are many remedies in our materia medica especially suitable for these conditions, a few of which I wish to mention, with their leading indications.

*Naphthalin*.—This remedy is one of the more recent coal-tar derivatives. The indications are: Paroxysms of extreme length. A sense of constriction about the chest preventing inhalation, or as if patient could not complete expiration. Great dyspnoea, relieved by violent motion. Feels better in the open air. Great soreness of chest and abdomen, must loose the clothing.

This remedy is only known clinically, but has proven a remedy of pre-eminence in the treatment of pertussis, spasmodic coughs, asthma, hay fever, and pulmonary emphysema.

*Drosera rot.*—All the symptoms are worse after midnight. The cough is short, croupy, and so rapid that the patient can scarcely get his breath. The chest seems to be constricted, causing distress. Patients support the chest with the hand for relief. Cough excited by dryness of the throat or tickling, as from a feather. Vomiting of mucus and blood.

*Corrallium rub.*—Smothering sensation occurring before the cough and great exhaustion following it. The cough is so violent that patient becomes black in the face. Is accompanied by a short crowing inspiration, styled the "minute-gun" cough. Comes on in the evening. This remedy is indicated when there is extreme violence, followed by great exhaustion.

*Ipecac* indications are those characteristic of this remedy. Vomiting during and between the attacks. Suitable in the second stage of an accompanying bronchitis, with a number of râles in all portions of the chest. Also when hæmorrhage occurs. Spasm of the glottis occurring before the paroxysm.

*Mephites*.—A complete suffocative feeling. Unable to exhale. Vomiting of all the food. Cough hoarse, croupy, with a moist edge.

*Belladonna*, if employed early in an attack of pertussis, or later, if cerebral symptoms are present, acts beneficially. The paroxysms are frequent, made up of a few coughs, with a short interval between attacks. The sound is hollow and of a barking character.



*Cuprum*.—Paroxysms very long and uninterrupted; also very useful when convulsions occur. *Coccus cacti*, *ambra-grisia*, *cina*, *verat. alb.*, *tart. emet.*, *senega*, *kali bi.*, and *arnica*, are all of great value in the treatment of pertussis.

My experience with naphthalin in whooping-cough is as yet limited, but the results obtained have very much exceeded other remedies, and I wish to cite a few cases in which the alleviation of the symptoms was soon appreciable.

CASE I.—Francis —, a boy of 9 months, with a severe bronchitis as a complication. The breathing was labored. The respiratory murmur was feeble and a large number of sibilant and sonorous râles were heard, when I was called to see the case. The child had become emaciated, had a cyanotic appearance, was unable to retain food for any length of time, because of the frequent paroxysms accompanied by vomiting, and was very much exhausted. Later, the moist râles became very prominent over the entire chest. The paroxysms were of great length, and accompanying was a free discharge of thick, tenacious mucus from the nose and mouth. Many of the favorite remedies employed in this disease were prescribed, but with little effect. Naphthalin was then given, four or five drops of the tincture in one-half glass of water. In a short time the paroxysms were lessened in severity and frequency, the expectoration was freer, the number of râles were lessened, and shortly convalescence was well established.

CASE II.—John — 3½ years, with an accompanying bronchitis. Symptoms worse at night. Paroxysms very long and severe; would hold his head to relieve the pain from coughing. Great difficulty experienced in breathing. A number of râles heard over portion of the chest, with little expectoration. After naphthalin had been given for a short time improvement began, and terminated without further complications.

CASE III.—Patrick —, a man 23 years of age, large physique and healthy appearance, contracted pertussis from other members of the family, and, although not accompanied by the whoop, the paroxysms were very severe. They were not frequent during the day but many during the night. He would wake the entire house by coughing and would become purple in the face. He had been suffering a week or two before I saw him. I prescribed *drosera*, *corrallium rub.*, *ipsecac.* and *hyoscyamus*, without appreciable improvement. He gradually grew worse until naphthalin 1x in pellets was given. The spasmodic condition was relieved very shortly, and although the cough remained for a time, it never became severe and soon entirely disappeared.

## RETAINED FÆCAL MATTER—ITS RELATION TO DISEASES OF THE ALIMENTARY AND GENITAL TRACTS, AND ITS TREATMENT.

BY EDWARD MAGEE DEACON, M.D., BIRDSBORO, PA.

(Read before the Homœopathic Practitioners' Association, Reading, Pa., June, 1897.)

THIS condition I will define as an accumulation of fæcal matter which always remains in a portion of the intestinal tract of many persons after an attempt at defecation, and which cannot be expelled by Nature's unaided efforts.

As a causative factor, it is often overlooked in the treatment of diseases of the alimentary and genital tracts. Some persons may have what they think is a good-sized stool every day or two, and yet have a fæcal accumulation somewhere in the large intestine. This, if allowed to remain, will in time give rise to a train of severe symptoms which, if the condition is not recognized and promptly relieved, will cause the patient much suffering, and lead to marked pathological changes in the tissues involved.

During the past three years I have repeatedly seen patients, many of whom had no thought of being constipated at the time, suffering from attacks simulating a general peritonitis, relieved in a few minutes by an enema which caused to be expelled large masses of hardened fæcal matter, when they had suffered for several days before seeking medical aid.

We should always be on the lookout for this condition, for its development in many cases is insidious. The superficial observer is apt to be thrown off his guard, thus attributing the patient's suffering to an entirely different source. In every case the frequency, size and character of the stool should be investigated thoroughly.

The fæcal accumulation may be situated anywhere in the large intestine, but I have noticed it more frequently in the rectum, sigmoid flexure and cæcum. It may be either hard or soft. Its character and situation, however, do not favor expulsion. Females are affected more frequently than males, and it is found in the infant as well as in the adult.

*Causes.*—Sedentary habits, improper food, imperfect diges-

tion, atony of the bowel, certain drugs, such as lead, opium, stricture of the bowel, due to disease or injury; pressure of various organs; complete laceration of the peritonæum, and disease or injury to the centre controlling the act of defecation.

The *symptoms* vary according to the size and situation of the mass. The history of some cases will often lead us to ignore this condition as a cause of disease in certain organs. In our haste to devote our attention to the part supposed to be involved, we do not stop to consider the fact that the pain is reflex, and therefore due to an irritant elsewhere. We may or may not have a clear history of constipation upon which to base our conclusions. The passage of flatus or of a medium-sized stool do not indicate that such a condition is not present. The intensity of the pain is variable. Vomiting, when present, is due to irritation, either reflex or local. The vomited matter usually consists of mucus, bile or food; but in cases where the lumen of the bowel is obliterated, it is fæcal in character. Dull frontal headache and mental irritability are nearly always present. Pain cannot be endured easily. There is restlessness at night. The tongue is heavily coated, and there is an unpleasant taste in the mouth. The temperature is somewhat higher than normal. I have seen it as high as  $103^{\circ}$ ; this, I believe, was due to auto-intoxication, the result of decomposed fæces.

In diagnosing this condition, physical signs are indispensable. Inspection will show any irregularity of the abdominal surface if the accumulation be of sufficient size. Palpation should be employed with the thighs flexed upon the abdomen, and will often enable us to detect the presence of an accumulation when other methods fail. The percussion note over the seat of the trouble is usually dull, but in some cases it may be flat. The surrounding area is tympanitic or normal.

In the writer's opinion, many cases of typhlitis and appendicitis are due to fæcal accumulations lodging in the cæcum and remaining there an indefinite period, thereby producing an irritation which results in an inflammation of this portion of the bowel (typhlitis); or if small particles of fæces work their way into the lumen of the appendix, we have an irritation of that organ which usually results in an inflammation (appendi-



citis). It is not unusual, after an appendectomy, to find the lumen of the appendix filled with faecal matter.

Enteralgia and gastralgia are frequently the result of an irritation produced by the presence of retained faecal matter, together with the gases which are generated and often pent up by the same. Very small-sized accumulations are sufficient to cause this irritation.

Coming now to the genital tract, we find that retained faecal matter is capable of producing a variety of diseases and conditions. Organs in which disease already exists are sure to be greatly irritated. The irritation, having once occurred, is apt to be rekindled by a very small-sized faecal accumulation. Thus an acute condition gradually merges into a chronic one. Malpositions, especially retro-positions, of the uterus are greatly aggravated. Many cases in which adhesions complicate the displacement are benefited by ridding the rectum of scybalous masses. Ovaritis, ovaralgia, salpingitis, endometritis, metrorrhagia, menorrhagia and dysmenorrhœa are likewise aggravated. No matter what the disease is, a faecal accumulation should always be looked for very carefully and removed when found, in order that the real source of the disease may be detected.

I desire to report the following cases :

CASE I.—Female; aged 55 years; mother of five children. At different times during the past fifteen years has had sharp shooting pains in both inguinal regions, but worse on the left side. These were accompanied by a bearing-down sensation in the hypogastric region. Appetite was fairly good. Sleep variable. Marked hysterical tendency. Examination revealed a prolapse of the uterus in the second stage, bilateral laceration of the cervix, slight laceration of the perinæum, whitish leucorrhœal discharge, and quite a number of hæmorrhoids. There was an area of dulness as large as the palm of my hand in the left inguinal region. Palpation through the abdominal wall revealed the presence of a resisting mass at this point, but palpation per vagina and rectum gave no such result. This case is interesting because the patient did not think that she was constipated. She had had a daily stool for several years, but nevertheless employed a daily enema, which was used while in a sitting position. Medicine was given for a few days

before making the examination in order to gain the patient's confidence, but its effect upon the pains was *nil*. As soon as I completed my examination I ordered an enema according to the method which I shall describe later. The result was marvellous. Large masses of fæcal matter were expelled. In a few minutes the pain ceased. The dulness and resisting mass disappeared. The nervous condition improved, and there has been no recurrence of any of the former symptoms since. At first the injections were used daily, but later every two or three days. Of course an operation should be performed in order to restore the cervix and the perinæum to their proper condition, but the patient will not consent to this.

CASE II.—Female, aged 40 years. Mother of five children. Was summoned on the third day of her illness. She had had chills and vomited during all this time. The abdomen was hot, swollen, and tender to the touch. There was sharp pain in the right inguinal region. Dull frontal headache. Temperature was 102.5°. A slight amount of dulness was discovered at McBurney's point, and here also the tenderness was more marked. The bowels had moved just before I arrived, in fact they had been regular for some time previous to this attack. Owing to the extreme tenderness of the abdomen deep palpation could not be employed, but judging from the symptoms and the physical signs, and from what I had observed in similar cases, I concluded that the trouble was due to a hard fæcal accumulation in the cæcum, notwithstanding the fact that the bowels had moved but a short time before. An enema was given immediately, and a considerable quantity of hardened fæcal matter was expelled. The temperature gradually dropped to normal. The heat, swelling and tenderness disappeared, and in a few hours the patient wanted to sit up in a chair, but was not allowed to do so. The next day, however, she was down stairs. She avoided any further trouble by using the enema every day for a while, and then every two or three days.

*Treatment.*—The cause of the retained matter should be investigated and treatment prescribed accordingly. The diet and digestive power should be watched carefully. Electricity is often beneficial. Dilatation of the sphincter muscle is also useful.

As to palliative measures, salts and laxative pills are frequently used, but should not be pushed to the point of de-

ranging the stomach. Except in very mild cases, I have found them unreliable.

Injections, however, have been very successful in my hands. The method which I follow in giving them is not new, but nevertheless a description of it may not be amiss. I invariably use a two-quart fountain syringe, filled with warm water, in which are dissolved two or three tablespoonfuls of sweet oil. The bag is shaken and hung on a nail or bedpost. The patient is directed to lie on the left side, with the hips considerably elevated. Either a long or a short nozzle can be attached to the tube, but this will depend on the situation of the fæces. If they are low down a short nozzle can be used, but if high up a long rectal tube will be of service. The end of the nozzle or tube, having been lubricated with vaseline or lard, is pressed against the sphincter muscle for a few seconds, to overcome any spasm of this body. It will now slip into the rectum. The buttocks should be pressed together and the current turned on. As much of the fluid should be used as can be retained in the bowel for some time. There will be some pain, but this is merely due to distention of the bowel. When the injected fluid is expelled we can determine whether or not the enema was a success. If it was not, a second one should be employed. Oil, though a trifle more expensive, gives better results than does soapy water.

The more important remedies are: *Nux vomica*, *alumina*, *opium*, *causticum* and *plumbum*.

In summing up the subject, I desire to emphasize the following points:

1. That retained fæcal matter is an abnormal condition and occurs very frequently.
2. That many diseases and conditions are due to such a condition.
3. That it is not always easily recognized.
4. That the treatment should be directed to the source of the trouble, and that the injection of oil and water, or of oil alone, constitutes the best and safest palliative measure.

---

DIGITALIS TABLETS INERT.—From a number of experiments, Dr. Judson Daland concludes that tablets of digitalis made from the tincture are inert.—*Medical and Surgical Reporter*, December 4, 1897.



## THE DIAGNOSIS AND TREATMENT OF URETHRAL STRICTURE OF LARGE CALIBRE.

BY LEON T. ASHCRAFT, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Phila., March 10, 1898.)

MY reason for presenting this subject before this Society will be apparent by recognizing the fact that the presence of large-calibre stricture is largely responsible for the continuance of a chronic urethral discharge, and moreover, without its removal, no gleet can be cured.\* Also, because they contract to a small calibre, producing the alarming symptoms so well known to all; but if recognized early these strictures can be removed without endangering life. Their presence may be assumed when gleet persists, and positively diagnosed by urethral exploration. The instrument usually employed for this purpose is Otis's urethrometer. It should be perfectly clean and well lubricated with a 25 per cent. solution of boroglyceride, and passed (if the tube permits) to a depth of  $5\frac{1}{2}$  inches. Its bulb should then be enlarged to suit the calibre of the urethra, and an attempt made to withdraw the instrument. While no absolute rule can be laid down regarding the calibre of the urethra, nevertheless Otis maintains that a normal canal should allow the passage of a No. 30-F sound.

The following is the scale adopted at the Hahnemann Hospital Dispensary:

A penis having a circumference of three inches should admit a 30-F sound. For every increase or decrease of a quarter of an inch in its circumference two millimetres should be added or subtracted. During urethral exploration, if the points of normal narrowing of the anterior urethra at the middle of the spongy portion and the meatus are recalled, errors in diagnosis cannot occur. Moreover, strictures of gonorrhœal origin are most frequently encountered in the first three inches of the urethra, and quite often situated in the region of the bulb.

\* Otis, *Stricture of the Male Urethra*. Holmes's *System of Surgery* (American Ed., vol. ii.). Ashhurst's *Text-Book of Surgery* (6th Ed.). Belfield's *Diseases of the Urinary and Male Sexual Organs*. Keyes's *Genito-Urinary Diseases and Syphilis*.

Following this operation the canal should be irrigated with 1:5000 solution of nitrate of silver.

*Treatment.*—Strictures of large calibre may be treated by gradual dilatation or internal urethrotomy, the choice of treatment being determined by their location and character. The followers of Oberlander maintain that strictures of large calibre should be dilated. Otis teaches that they should all be cut. Perhaps it may be well to submit the treatment followed at the Hahnemann Hospital Dispensary. An attempt is made to dilate all before resorting to a cutting operation, the exception being given to those situated about the fossa navicularis. Very hard, irritable strictures should be cut, and congenital narrowings about the meatus should likewise be cut; other varieties dilated. The object of instrumentation is to enlarge the calibre of the urethra by the process of absorption. This can be accomplished in the majority of cases by gradual dilatation, the necessary instruments for which are a set of curved sounds, Kollman's four-branched anterior dilator, Oberlander's curved dilator, and Kollman's four-branched posterior dilator. Curved sounds are universally employed to dilate strictures. Their mechanism and technique of employment are familiar to all. Kollman's dilators are the best instruments as yet invented for the treatment of urethral narrowings. They are protected by a rubber cover, thereby preventing their blades from injuring the walls of the canal. The anterior dilator has four branches, which may be dilated from 20 to 45—French. When introduced into the opening of a stricture it may be allowed to remain there until the necessary degree of dilatation desired for one sitting is obtained. With this instrument it is possible to obtain fractional degrees of dilatation. Its mechanism makes it peculiarly adapted for the treatment of hard, dense strictures of the anterior urethra. The curved dilator of Oberlander is used for the dilatation of the bulbous portion of the urethra. Kollman's four-branched dilator for the posterior urethra is well adapted to the dilatation of hard strictures about the bulbar membranous junction. Before introducing any instrument within the urethra it is advisable to cleanse the canal from the pyogenic organisms so frequently present in these conditions. The foreskin, glans penis and meatus should be irrigated with 1:5000 solution of bichloride of mercury. Every instrument

used for urethral treatment must be sterile. Before using sounds they should be placed in boiling water, dipped in alcohol, and flamed off. It is unnecessary to observe these precautions when employing a dilator, or, indeed, any instrument that is protected by a rubber cover. Only decent cleanliness is required. The covers of these instruments, however, should be placed in a pan of hot water containing a 5 per cent. solution of carbolic acid. Before using they should be dried. A little cornstarch dusted over the dilator makes it an easy task to draw on its covering. These precautions having been observed, and the size, character and location of the stricture ascertained, treatment may be commenced, provided neither acute posterior urethritis nor systemic conditions exist. Recent soft infiltrates of the pendulous urethra are readily absorbed by using steel sounds. The size selected should be two millimetres smaller than the opening of the canal. After lubrication with a 25 per cent. solution of boroglyceride, an attempt should be made gently to pass the sound slightly beyond the strictured area, the patient occupying the recumbent position. Should the meatus be too contracted for this instrument it should be cut, and deeper urethral treatment postponed until the wound heals. Should the sound selected fail to pass the stricture, several sizes should be tried until the proper one is found. It should then be withdrawn and the urethra irrigated. Following this operation there is burning during urination and an increase of discharge. These unpleasant symptoms, however, pass away within twenty-four hours, and after four days, unless complications occur, the operation may be repeated, increasing at each sitting the size of the sound two millimetres, until the full calibre of the canal is restored. This can be demonstrated only by using the urethrometer. If gleet persists, we must look to erosions as a cause. Hard, dense strictures of the pendulous urethra may disappear after repeatedly using Kollman's anterior dilator. This operation is performed by gently passing the instrument through the strictured area and slowly turning the screw to the right, by this means separating the blades and obtaining that degree of dilatation desired. Dilatation must cease when the patient feels a degree of the slightest pain. This passes away within a few minutes, when additional dilatation may be obtained. The great danger offered by this



treatment consists in attempting too much dilatation at one sitting. A good rule to observe is not to attempt to obtain more than two millimetres of dilatation at one sitting. Lesions of the bulbous portion usually disappear when dilated by the curved instrument of Oberlander, but if they should not, Kollman's four-branched posterior dilator will usually effect a cure. The latter instrument is particularly indicated when we have to dilate a hard, dense stricture. The same rules should govern dilatation in this region as elsewhere. Should complications arise, dilatation should be suspended and proper treatment instituted. It must not be forgotten that immoderate indulgence in alcoholic beverages or sexual intercourse during treatment is largely responsible for the continuance of a discharge. The class of strictures demanding internal urethrotomy having been mentioned, it remains but to briefly describe the operation.

For operations upon the meatus and fossa navicularis, a blunt tenotome answers admirably. The precautions to be observed, when operating on any part of the urethra, are as follows :

The entire canal should be irrigated with 1 : 5000 solution of nitrate of silver for several days before the operation. A few minutes before operation the glans penis and foreskin should receive a thorough cleaning. All instruments used are made perfectly aseptic by boiling and immersing in a 5 per cent. solution of carbolic acid. The operation may be rendered painless by injecting two drachms of a 4 per cent. solution of eucaïne, as suggested by Dr. Benson. Meatotomy is performed by slowly cutting upon the urethral floor-line. Ability to pass the proper size-sound demonstrates the success of the operation. If carefully performed, complications never result. Hæmorrhage is controlled by packing the meatus with a strip of iodoform gauze. The after-treatment consists in passing a full-sized meatus-sound every day until the wound heals. Otis' dilating urethrotome is well adapted for the division of strictures of large calibre, since it possesses the double advantage of cutting and dilating at one time. This instrument is introduced slightly beyond the stricture and is then dilated to several millimetres beyond the urethral calibre. The division of the stricture is accomplished by withdrawing the knife from its

groove, and freedom from narrowing is demonstrated by the ability to withdraw a full-sized bulbous sound. The operation is performed under eucaine anaesthesia, the incision being made upon the roof. Haemorrhage may be controlled by applying a firm bandage to the penis. Provided no complications occur, three days after the operations a full-sized sound should be passed and the urethra thoroughly irrigated. These procedures are repeated every three days until the wound heals. The complications to be dreaded in internal urethrotomy are urethral fever and death. A fatal complication may usually be attributed to a severe urethral fever which may be averted by a rigid observance of antiseptic details.

Incurvation of the penis following internal urethrotomy is an occasional, permanent annoyance. Even after the urethral calibre has been restored, gleet may be present. In such cases the urethroscope will usually detect slight areas of denudation. Local treatment with a strong solution of nitrate of silver is indicated.

It is to be regretted that dilatation is not indicated in the treatment of every urethral stricture, since a method attended with such little personal inconvenience can but commend itself to both physician and patient.

---

ON THE OCCURRENCE OF RETINAL HÆMORRHAGE AFTER MIDDLE AGE, AND ITS BEARING ON THE DURATION OF LIFE.—The writer relates the history of a case of retinal hæmorrhage occurring in a man of sixty, actively engaged in public life, who had been warned to regard the disease of the eye as a forerunner of something worse, and to change his course of life. This advice was not followed, and twenty months afterward he had an attack of apoplexy, which proved fatal.

This history serves as an introduction to the paper. Dr. Derby points out the fact that the subject of the connection of retinal hæmorrhage with the condition of the general health is not dwelt upon by writers of ophthalmology at any length, and is ordinarily dismissed in a few words, all the authors, however, agreeing that, occurring in the aged, the symptom is an ominous one. While the effect on sight may be slight, it has a significant bearing on the duration of life. It may mean an atheromatous condition of the cerebral arteries or a cardiac lesion. The symptom is of great importance, and the prognosis serious.

The detection of the disease is easy. The cases are far from infrequent, and the warning given by their occurrence may be practically utilized for the regulation of important business interests and to prolong life.—Hasket Derby, M.D., Boston, *Boston Medical and Surgical Journal*.

## CORRESPONDENCE.

## THE BULBOUS URETHROTOME.

BY GEORGE CLINTON JEFFERY, M.D., BROOKLYN, N. Y.

THE need of an improvement upon the urethrotomes that have been employed by the surgical profession for a number of years past has been apparent to those who have had frequent occasions to use them; not but what the usual plan of dividing a urethral stricture has been more or less a successful one, but the detail which is required in applying the instrument, as well as its complexity of structure, adding many difficulties by the way of cleaning after use, offers room at least for the introduction to the profession of another urethrotome which is free from many of the objections possessed by the others.

The bulbous urethrotome is simple in mechanism, easy of employment, and locates promptly and holds effectually the stricture during the period of its division. With the detail of preparation required in the use of the urethrotome devised according to the plans of either Otis or Gerster much of their inefficacy, in my judgment, exists. It is the first requisite that the site of the stricture be positively identified. Next, it is essential that the identified point of location be not lost until the moment for its division has arrived. The fact that these essentials are made difficult and uncertain by present methods is offered as a reason for our belief that there exists room for some improvement. By the present plan the surgeon is required to mark with his finger upon the bulbous bougie, which he must first use to locate the stricture, the exact distance within the urethra when he finds it existing. He must then retain his hold on the bougie until the urethrotome is ready to be introduced in its stead, so that he may indicate the distance from the meatus urinarius, where he expects to apply the knife. Often a mistake is made in acquiring these measurements; and, as I have often found after I have finished with the urethrotome,



the stricture remaining intact and uncut. I have endeavored in my instrument to obviate these difficulties and add ease to the operator. Besides, the price of the instrument will be found at a much lower figure than what is usually charged for the usually employed urethrotomes of others. The following description will, I believe, serve to make clear the plan of manipulation, and will promptly demonstrate the simplicity and value of the instruments:

The cut represents the instrument as it appears within the urethra when the moment for the dividing of the stricture has arrived. At other times the parts represented by A and B B lie closed and partly hidden within the canula, although A, which holds the knife-blade, is hidden within the closed parts B B, which form a bulb, which is acorn-like in shape, and which protrudes from the canula. The canula, in a case of suspected stricture, is passed into the urethra until the triangular ligament is reached, which point retards the further progress of



the instrument. This is about five inches from the meatus urinarius. When this point is reached the canula is slipped backwards, with the assistance of the hand-screw F, when the bulbs B B begin to separate until the sides of the urethra are placed upon a stretch. The surgeon now gently but firmly begins to withdraw the whole instrument, when the presence of any existing stricture will be at once engaged in the divided bulb, B B. The surgeon now draws backwards and forwards the handle E, which controls the action of the knife-blade A, and the stricture is at once divided. It will at once be seen that when the stricture is identified the moment for its division at once occurs without removing the instrument, so as to have it replaced, the stricture being held fast and tense over the bulb-surface. On the canula will be noticed a graduating scale, which at a glance seems to indicate the depth of the stricture within the urethra.

These instruments are being manufactured by Fred Haslam & Co., surgical-instrument makers, Brooklyn, New York.

## EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

## MEDICAL COLLEGE EDUCATION.

It will no doubt be a source of gratification to the many friends of the Hahnemann Medical College of Philadelphia that it is about to make use of its semi-centennial celebration, to take place in a few days, not for purposes of self-glorification, but to hold a congress of homœopathic college workers to discuss a number of questions of the utmost importance.

These were mentioned in this department in last month's issue, but for convenience's sake we restate them :

1. The Use and Abuse of the Didactic Lecture.
2. The Province and Value of the Laboratory in the Medical Course.
3. How can the Teaching of the Specialties, in the Undergraduate Course, be made to serve its best Purpose—the Qualification of the Student for *General Practice*?
4. The Proper Place and Period of Clinical Work in a Four Years' Course.
5. Preparatory Studies and Preparatory Departments in Medical Colleges.

The Relation Between the Literary School and the Medical College will also be made the subject of discussion at a Public Meeting, to be held on the evening of May 11th.

The discussion of these points will be calculated to bring out the best thoughts of medical educators in our school, and cannot fail to have a widespread influence for good.

Without desiring to criticise, we think that the whole discussion might well have been opened by a paper setting forth clearly what should be the acknowledged purpose of the education offered students in our medical colleges. Without such purpose kept distinctly before the mind there is sure to be much aimless and illogical tampering with established precedents. We think, indeed, that without this key-note convincing answers to the questions proposed will, in most cases, be impossible. It is true in the third topic there is an allusion to a "best purpose" of the teaching of the specialties, viz., the qualification of the student for general practice. There should be no "best" purpose in the undergraduate course, but only

one, and the entire plan of specialty teaching, as well as that of all other teaching, should be directed solely to this end, the qualifying the student for general practice. The medical college in its regular course is not the place to make specialists, nor scientists; a curriculum arranged with either of these ends in view would be unjust to those intending to pursue a general practice. The place for such advanced teaching is a post-graduate school, while the limited amount of specialism necessary to complete a general medical education naturally and logically falls in the latter part of the undergraduate course. A clear recognition that it is not the province of a medical college to make scientists will assist also in recognizing the use of didactic lectures, at the same time that it will guard against their abuse. A scientific therapist is quite another person from a medical scientist; it is within the range of possibility for our colleges to produce the former, *in spe*, while the endeavor to turn out the latter, *in re*, must result disastrously to the best interests of the majority of the students.

We all know the mass of science which lies at the foundation of the art of medicine; we know that it is the result of a slow accretion of individual efforts covering long periods of time, and yet we too often find in didactic lectures an effort to lead the sorely burdened mind of the student through the various steps which have led finally to the establishment of acknowledged results. Formerly the abuse of didactic lectures took the form of being too theoretical; now the danger is in making them too scientific. The words are not synonymous; the first we oppose to the practical, the last to a concise statement only of the immediate scientific data upon which the practical is based. No matter what may have been the abuse of the didactic lecture in the past, and no matter what it may be at present, nothing, in our estimation, can ever be made to supersede it with benefit to the student.

We quote from a Western journal:

"We observe that the trustees of the Western University Women's Medical College are following the plan inaugurated by the College of Physicians and Surgeons of San Francisco more than a year ago, of doing away largely with didactic teaching, claiming that a real medical education must be obtained in the laboratories and in clinics where the student is brought into actual contact with every phase of disease."



We take decided exception to the claim advanced. The natural course in the acquisition of all scientific knowledge and its practical application is first analytical, then synthetical, and then again analytical. A host of workers have collected innumerable observations, which have been and are being arranged into a science, and in the light of this synthesis a new practical analysis is to be undertaken, and the systemized knowledge applied to individual cases. By abandoning the didactic lecture, which is, or at least should be, the statement of the end-results of innumerable observations, we virtually take the student back to the primary analysis, and attempt, by a limited number of clinical cases, laboriously to arrive at a synthesis which has already been obtained by countless observations. No; let the didactic lecture remain as the exponent of the end-product of the united wisdom of the past, and let the clinics and the laboratories be used to illustrate, to verify, or to disprove, but never to supplant. In no clinic, however large, can the "student be brought into contact with every phase of disease."

This point of view, if correct, will at once cause the clinical work to fall into its proper place and period in a Four Years' Course. It will naturally and logically follow the completion of the didactic course in any particular branch. Having learned what others, more experienced than himself, have seen and observed, the student will know what to look for and how to interpret his observations. He is not, even at the close of a four years' course, in a condition to risk original deductions from personal observations, but under proper guidance can learn how to observe, and, having been provided in the didactic lectures with a scientific schema of a subject, will know how to utilize the results.

It would surely be deemed irrational to compel a student to build up the concept "man" from a consideration and study of the few men who could be brought under his personal notice.

As at present constituted, the medical course cannot be regarded as a period for original research; hence all laboratory work can only have for its legitimate object the illustrating of known facts. As a means of elucidating and impressing subjects upon the mind and memory, practical laboratory work

cannot be surpassed; but an endeavor to assign to it the highest position in the medical curriculum would be both illogical and irrational.

In the reaction against the slipshod methods of the past, and in the interests of a higher standard of medical education, we are going too far. To avoid an excess of pure theory we are exalting the practitioner unduly, and in the place of a confessedly incomplete and superficial knowledge of medicine as a whole, we are seeking to substitute a complete and thorough knowledge of the whole of medicine. We are striving after a standard for all our graduates which the existence and prominence of the specialties in medicine prove to be attainable by but few, and then only after years of experience.

The same train of thought will guide us in considering the last topic in the program, Preparatory Studies and Preparatory Departments in Medical Colleges.

Here the first thing to be noted is the radical difference between preliminary education and studies preparatory to the study of medicine. Sometime during the past year we said that, in our opinion, in order to become an ideal medical college, each institution should have a preparatory school of its own, where all preparatory studies would be provided for, so as to leave to the college itself only those branches strictly medical or surgical. In that way, and in that way alone, could we hope ever to reach the ideal towards which we are striving, even with a four years' course.

The failure clearly to recognize the object of "preliminary education," as demanded by medical educators, has led to the various vagaries and abundant absurdities promulgated by Boards of Regents and Boards of Medical Examiners. However desirable, medical educators do not demand that their matriculants should have such an education as the possession of a degree from a College, or High School, or even an Academy, is supposed to represent, but only that they should have been trained to observe and to think, and are prepared to undertake the study of medicine even if only in its preparatory branches. Without intending to belittle the advantages of a collegiate course, or the benefits—principally to the possessor—of the wider culture and outlook afforded by such a discipline, we do not think they are essential to the study of medicine.

At the risk of seeming to exaggerate, we would maintain that a preliminary education in English grammar and a common-school arithmetic *could be made* to prepare a student for the study of medicine as fully as the more pretentious curricula of many colleges.

When it comes to preparatory education, we have quite a different matter to consider. What shall constitute a preparatory course of study is a question which each medical school is called upon to determine for itself; and yet, until each possesses its own preparatory school, it is expedient that there should be such an unanimity in their demands that existing institutions could, for the present, answer them.

To attempt to enumerate those branches which should be included in a preparatory course, and to defend our position in each case, would lead us too far, but a general principle to govern in the choice could, we think, be laid down. All those sciences which have furnished basal data upon which the science and art of medicine are founded, not strictly medical in themselves, should be regarded as necessary preparatory studies, but only in so far as they bear direct relation to the development of medicine. All those branches of study, some knowledge of which is necessary to the comprehension of medicine, should also find place in a preparatory course.

Only these and nothing more.

These may seem self-evident propositions, and liable to become too comprehensive; but if taken in connection with a clear grasp of the true and only purpose of the medical education to follow, they will prove reliable guides to a final decision.

We predict great good from the discussion of these topics. A ventilation of views is of great importance to Homœopathy at the present time. We are no pessimists, but we cannot but feel that there are influences and tendencies in our school which, although perfectly legitimate in themselves, may, if not properly regulated, be productive of great harm to our cause.

We hope for the best.

---

**RTA IN RHEUMATISM.**—Rheumatic lameness of the wrist and tarsal joints; pains as from a blow, fall, or as if crushed, aggravated by touch. bending the body or the affected joints, and relieved by continual motion; sense of want of power or partial paralysis.



## GLEANINGS.

---

**PULMONARY TUBERCULOSIS, WITH PRESERVATION OF THE NATURAL PLUMPNESS.**—Dr. Queyrat (Paris) recently exhibited two patients before the Paris Hospital Society who, with tuberculosis of the lungs in full development, retained their natural plumpness.

In the discussion, Dr. Du Cazal remarked that not only may one retain the normal quantity of adipose tissue, but also the muscles may apparently remain unaffected.

Dr. Chauffard said that he had at present under observation a patient who, though manifestly tuberculous, still, muscularly, was athletic.

Prof. Debove stated that he has seen two porters of the corn market of Paris who, though in the second stage of the disease, were yet able to follow their occupation.—*La Semaine Médicale*, No. 34, 1897.

Lænnec—*A Treatise on Diseases of the Chest and on Mediate Auscultation*, p. 363, 1830—under latent phthisis, states "That it is by no means rare to meet with cases in which the characteristic symptoms show themselves only a few weeks, or even days, before death. . . . I have known of several cases where it has been concealed for years by a habitual dyspepsia and other symptoms of hypochondriacism. One of these, a confirmed hypochondriac of ten years, and who still preserved his strength and plumpness, was suddenly attacked by an acute catarrh, which was succeeded, after five days, by expectoration of puriform mucus, mixed with a little blood. These symptoms subsided in the course of a few days, but after six months they were succeeded by symptoms of a decided phthisis, which carried the patient off within six weeks."

Prof. Goodno—*Practice of Medicine*, vol. i, p. 364—in discussing the group of cases beginning with hæmoptysis, mentions having observed an iron-worker, 36 years of age, a large and well-developed man, with an excellent personal and family history, where, after the first hæmorrhage, a minute examination failed to reveal anything suggestive of previous pulmonary disease. The heart and other important organs were normal. After examination, he felt that it would be difficult to select a better specimen of healthy manhood; and yet this man, while pursuing his usual work, and without evidence of unusual strain, suddenly expectorated a few ounces of clear blood. There were three recurrences of the hæmorrhage within a month. By the end of this time consolidation could be detected in the right apex.

**IODINE IN DISEASES OF THE CIRCULATORY APPARATUS, AND ESPECIALLY IN ANGINA PECTORIS.**—Dr. Vierordt (Heidelberg), as he has found the results of dietetic, physical and similar treatment often to be insufficient in heart diseases dependent on arterio-sclerosis, he decided five years ago to try the long-continued use of iodine, as has been suggested by Huchard and other French writers. The patients were partly arterio-sclerotics, without heart

symptoms, and partly those with associated cardiac lesions, especially angina pectoris. Cases with albuminuria, persistent cardiac weakness, and those over sixty years were excluded. Sodium iodide was prescribed in doses of  $\frac{1}{4}$  and  $\frac{1}{2}$  grammes, with a daily dose of  $1\frac{1}{2}$  to 3 grammes, in milk or seltzer water, and later the iodide of potash, in the form of Sandow's effervescent salt. The chief feature was that the patients took the iodine for a long time, though with interruptions, so that in the course of the first year, for about nine months, the above dose be ingested. Later, the remedy may be used interruptedly from time to time. With intercurrent heart weakness the iodine may be given, together with digitalis, nitro-glycerine, etc.

The drug was well borne, and no idiosyncrasy was noticed in some twenty cases. Moderate "iodine-coryza" was observed, and the drug discontinued for a period, to be resumed. In a few cases the treatment had to be discontinued on account of gastric intolerance, while in the majority its influence on both appetite and nutrition was strikingly favorable. The results in the arterio-sclerosis were undoubted; they were most decided in patients with heart complications and, above all, with angina pectoris. For strict critical consideration, those cases which had been treated dietetically were most appropriate, and who for a series of years—2 to 4—were under observation. Of such there were six, of which there were five with very severe angina, where the results were very striking and even brilliant. There was return of strength so that they were able to work, which before had been entirely impossible; they were able to walk and ascend heights, while previously they had had fainting attacks and severe heart pang, so that walking on a level street was out of the question. In about half of the cases of angina pectoris from sclerosis of the coronary arteries, one may hope for a long-lasting result from this treatment. It is of little importance whether the disease has originated from syphilis or not. The vascular degeneration apparently comes to a standstill, the blood-pressure sinks, although the vascular changes do not retrogress.—XV. Congress fuer Innere Medicin, Berlin.—*Wiener Medizinische Presse*, No. 28, 1897.

Prof. G. Lemoine—*Manuel de Therapeutique*, 1894, p. 194—in speaking of the preventive treatment, advises combating the arterial hypertension and the aortitis. "C'est le traitement par les iodures alcalins qu'il faut employer, et Huchard a magistralement réglé leur emploi." In order to be of service the treatment must be continued for a long time, two or four years, about, for in lesions of the aortic orifice the angina is often only a symptom. Every day from 1 to 3 grammes of the iodide of potassium or sodium may be taken, according to the state of the myocardium, in a little milk, twice a day, morning and evening. If this treatment be continued for some time, there are decided chances that the mortality will fall from nine down to three out of ten (Huchard). It would be wiser to institute this treatment whenever there appear certain signs of atheroma or arterio-sclerosis, without waiting for the appearance of angina. In some cases these iodides are not tolerated, either on account of an idiosyncrasy or from imperfect elimination due to renal insufficiency. In this case one may use instead the tincture of iodine, x. to xv. gtts., before each meal, diluted in soup or water, or the iodide of iron. (These doses of the tincture seem unnecessarily large. Drs. R. Schmaltz and O. Schweissinger—*Die Arzneimittel*, p. 118—advise beginning with small doses for fear of an idiosyncrasy. Anyone who has ever read Fournier's pic-

ture of œdema of the larynx from an overdose of the iodides will remember it when he employs iodine.)

THE RELATION OF SOME NEUROSES TO PREGNANCY AND PARTURITION.—Prof. Tarnier (Paris), in a clinical lecture, considers the influence of pregnancy and parturition on hysteria, epilepsy, and especially chorea. As to *hysteria*, in a small number of cases the effect of pregnancy is favorable; it rarely disappears entirely, and sometimes it is aggravated, but often it exerts no influence at all on the neurosis. Now and then hysteria may break out during pregnancy (I have seen it do it.—*Trans.*), though this will rarely have been the first attack. Hysteria brings with it no dangerous complication, does not influence its course, and provokes neither abortion nor premature labor.

Schroeder—*Lehrbuch der Geburtshilfe*, 1874, p. 656—states that hysteric attacks may appear during labor, for he saw one case. Consciousness was not wholly lost, and the urine was free from albumin.

F. Ahlfeld—*Lehrbuch der Geburtshilfe*, 1894, p. 210—says that hysteric spasms are very rare during pregnancy and parturition. Pregnancy frequently places hysteric women in a good somatic and psychic condition. He has seen hysteric attacks set in from long-continued distension of the perinæum, with distressing pain.

Auvard—*Tratado Practico de Partos*, 1891, p. 483, Spanish transl.—has found attacks during parturition rare. Some women may be hypnotized during the stage of dilatation.

In the majority of cases *epilepsy* is favorably affected by pregnancy. Only in one-fourth was no action noticeable; in another fourth pregnancy aggravated, increasing the seizures in frequency and intensity, so that even death may occur during an attack. Epilepsy, on the contrary, may break out during pregnancy, cease with it, and only reappear with the next one. Usually the disease remains without influence on the patient, though death of the fœtus during an attack has been recorded. A difficult point is a diagnosis between an epileptic and an eclamptic seizure. The symptomatology is the same. One should search into the antecedents of the patient, and not forget that albuminuria may appear after a series of epileptic paroxysms, and that epileptic *easily become eclamptic*.

Auvard (l. c.) claims that pregnancy generally alleviates epilepsy.

Ahlfeld also has noticed the same. He advises against allowing epileptic mothers nursing their children, as it acts unfavorably on the mother's health, and also she may drop her child if surprised by an attack.

Galen—*The Genuine Works of Hippocrates*, vol. ii., p. 743—instances epilepsy as fatal in pregnant women.

*Chorea*, though fortunately rare, is a serious complication of pregnancy. Sometimes it breaks out without any previous history, yet usually there will have been chorea during the patient's childhood. It may also recur with the next pregnancy. Its symptoms are those of the ordinary variety. All forms, from the mild to the grave, may appear, which latter is most frequent. Generally it persists through the whole pregnancy, and parturition increases its intensity. Amelioration follows, and gradual recovery appears after labor. Occasionally it may cause death from complications during pregnancy or labor. In about twenty per cent. it causes either abortion or premature labor. Its cause is the same as in the ordinary form. It ap-



pears chiefly in primiparæ, and during the first half of pregnancy. In grave cases one may be forced to bring on premature labor.—*Hospitalstidende*, No. 21, 1897.

Schroeder speaks of the great danger of chorea in pregnancy, and its tendency to leave psychic disturbances as sequelæ.

Ahlfeld states chorea to appear most frequently at the third month in the first and second pregnancies. "Nicht viel untersuchen!"

SAGE AS AN ANTISUDORAL.—Dr. Combemale (Lille, France) speaks highly of sage as a remedy in excessive sweating. In the night sweats of consumptives it is of service, for in two hours after its ingestion its effects are noticeable. This beneficent influence may continue for several days.

Krahn, in thirty-eight cases of excessive sweating in articular rheumatism, phthisis and leucæmia, has found it to have failed him but twice. He gives from twenty to thirty drops, morning and evening.—*La France Medicale*, No. 28, 1897.

Van Swieten and Sydenham were the first who called attention to the antisudoral virtues of this plant, especially in the profuse sweating of convalescents from acute diseases, as well as in those of consumptives.

Trousseau and Pidoux—*Traite de Therapeutique et de Matière Medicale*, vol. ii., p. 437, 1847—called this agent back from oblivion, and sought to explain how it was that this drug, which would cause sweating if taken by a person in good health, was able to act as an antisudoral. They admit that it is endowed with very active sudorific powers, and yet it is "preconisée pour arrêter les sueurs immodérées et débilitantes." Trousseau himself experimented with the drug, taking one-half ounce of an infusion of sage cold, which for several hours gave rise to abundant sweating, with flushes of insupportable heat; his pulse a little more frequent, but full; agitation during difficult mental work; thirst, dryness of the mouth, extraordinary constipation, increase of appetite, and a little insomnia.

Max Krahn (*Inaugural Dissertation*, Greifswald, 1896) confirms these observations of Trousseau, for, after taking increasing doses of the tincture, he suffered from abundant sweating, heat, dryness of the mouth, intense thirst; no desire for work; his pulse was rapid, complicated with vertigo, and even hallucination.

Cullen—*A Treatise of the Materia Medica*, vol. ii., p. 127, 1789 (the work which our honored Hahnemann translated, and of which I am fortunate to have a set)—also classes it as a sudorific.

"We must observe that it has been employed for restraining improper sweats. For this purpose Sydenham employed Malaga wine, but Van Swieten found sage infused in wine or spirits to be a more effectual remedy."

DIFFERENTIAL DIAGNOSIS OF SMALL-POX AND MEASLES.—Abu Beer Mohammed Ibn Zacariya Ar-Razi (900 A.D.) says in his work, *Al-Hawi*: "The difference between the small-pox and the measles I have found to be that the measles are red, and appear only on the surface of the skin, without rising above it, while the small-pox consists of round eminences. When these eminences appear fix your attention upon them, and if you are in doubt as to the disease, do not express any opinion about it for a day or two; but when there are no eminences, you must not give it as your opinion that the disease is the small-pox." He cites Baethishwa to the effect that "the

symptoms of the small-pox are fever, with redness of the face and body, and especially an intense redness of the gums. At the commencement of the disease, if the pustules are raised like berries, it is the small-pox; but if the red places are nearly level with the surface of the body, it is the measles."

Al-Yehudi also states that the measles are less elevated than the small-pox.

Avicenna—Canon IV., 1, 2, vol. ii., p. 36, L. 26, ed. Arab—also gives this differentiation. The Latin version of the Canon reads that "non est ei (sc. Morbillo) altitudo de qua curetur, proprie in principio sui. Variolæ cetero in principio suae apparitionis est eminentia et altitudo; et Morbillus est minor Variolis, et minus accedit oculo Variolæ."

Prof. Nil Filatow (Moscow)—*Semiotik und Diagnostik der Kinderkrankheiten*, 1892, p. 423—mentions the close similarity of measles and small-pox at the beginning of the eruption. In small-pox the distinct catarrhal symptoms and the exanthem on the soft palate, so characteristic of measles, are lacking, while the eruption has a more papular than a macular character. The small pox is slower in appearing and in spreading than the measles. *If there are more papules on the face on the first day of the eruption than can be counted*, then measles are probably present. This is a differential feature in those cases where, in measles, the catarrhal symptoms are tardy, and the eruption assumes a papular character. When not only the face, but the trunk, is simultaneously covered with the eruption, at the earliest the second day of the eruption, then differentially one will find that, 1, the measles exanthem is as abundant on the abdomen as on the chest, while in small-pox the abdomen is rarely attacked; 2, if the exanthem has affected the trunk in small-pox, then in the face, here and there, small vesicles will be noticed; 3, on the second and third days of the eruption the variola papules have no red areola, while in measles there is. *The efflorescences of measles are unequal in size*. The papules of measles are of a brighter color, while those of small-pox are of a pale rose color. The fever during the eruption of measles increases, while with small pox it decreases with its appearance.

FRANK H. PRITCHARD, M.D.

SUTURE MATERIALS AND METHODS IN CELIOTOMY.—In an article bearing this title which appeared in the *Monatsschrift für Geburtshilfe und Gynäkologie*, Dr. Hugo Stettiner, of Berlin, says, after speaking of catgut: "Turning now to other suture materials, silk, silkworm gut and silver wire, we do not even here find complete satisfaction. Although it is true that they are easily sterilized, the fact remains that certain authors report even more numerous infections with these than with catgut." Winter declares that silk, though the sterilization of it by steam seems complete, may serve as the avenue of approach of the organisms. Kocher is inclined to give the preference to a suture material that has been prepared antiseptically. In thirty-five goitre operations in which silk treated with arsenious acid was used he obtained complete healing by first intention. The second danger belonging to the use of materials which are not absorbed lies in the fact that after primary healing fistulæ may arise which do not heal until the foreign substance is expelled. This condition can also be traced to a subsequent entrance of micro-organisms. Winter has suggested that it might be prevented by a longer use of the occlusive dressings.

On these lines C. Dun experimented on ninety-eight rabbits by putting

under the skin bacterical cultures, or silk knots, sterilized, or impregnated with sublimate, or again with bacteria cultures. His results brought him to the following conclusions:

1. The larger the foreign substance, the greater the reaction on the surrounding tissue.

2. Ligatures soaked in sublimate cause more marked reaction than those which are sterile.

3. The same quantity of bacteria which, when alone, can be received by the body without causing any reaction, produces a strong reaction when the silk knot is present.

4. This reaction is less with knots soaked in sublimate than with sterile ones.—Translation by Hunter Robb, M.D., in *Cleveland Medical Gazette*, February, 1898.

**TREATMENT OF APPENDICITIS.**—In a paper read before the Kentucky Midland Medical Society, Dr. Louis Frank says: "There is never a time in the treatment of appendicitis when opium is indicated. I recognize full well that it is at times difficult to resist the temptation to administer a few doses of opium, especially after you have made the diagnosis, after you have convinced yourself, and there is no longer any doubt as to the nature of the trouble. We should resist the temptation, not because it obscures the diagnosis, it being already made, but because, pain being allayed, we are at once given a false sense of security. We may then think that our patient may get along without an operation. We go on from day to day giving one or two hypodermics, being all the time convinced that we have a case of appendicitis, but that the symptoms have subsided, and our patient goes on to death, simply because we could not refuse his pleadings, or had not the courage of our convictions. To my mind medical treatment should consist only in purgation with salines, or an attempt at purgation, the administration of enemata to empty the bowels, and hot applications; nothing more, unless at times strychnia as a stimulant."—*Atlanta Medical and Surgical Journal*, March, 1898.

**SURGERY OF THE JOINTS.**—In one of the Lane Course of Medical Lectures in San Francisco, Christopher Heath, F.R.C.S., says: "No one would think of excising a joint now when a very much less severe operation could be carried out; and that operation is an operation which is called arthrectomy. By which I mean that nowadays we open a joint which we cannot treat in any other way and scrape the surface of the bone, if it is exposed, or the cartilage, if that is bare, and we remove all the *débris* from the interior of the joint, and thoroughly wash it out, and then close the joint with antiseptic precautions, and we find that we get exceedingly good results. I do not hesitate to say that arthrectomy, as it is called, is now an operation fully recognized in England, and one which is saving a great many children's limbs.

"I may say that gonorrhœal rheumatism is held by some people to be a very troublesome and difficult thing to treat, and very likely to leave behind it ankylosis of a spurious nature—false ankylosis of the joint. I do not find this to be the fact. I find that with five-grain doses of quinine I can cure these cases rapidly, and within a week or two they are able to go out with a perfectly healthy joint. Of course, one puts on a bandage afterwards, and so on, to support the joint; but I mean that these patients are not confined for weeks, as they used to be, in splints, and they certainly do not lose the use of their joints.—*Occidental Medical Times*. F. WALTER BRIERLY, M.D.



WHEN IS OPERATION JUSTIFIABLE FOR FIBROID TUMORS OF THE UTERUS? —(Harrison). In a paper recently read before the New York Obstetrical Society he urges the following points :

A myoma is a benign neoplasm which causes no metastases, and injures the organism chiefly by its consequences and complications. It may be necessary to perform an operation on a woman who has to earn her bread by daily toil and is unable to work, which might be avoided in a woman similarly afflicted but in easy circumstances. He does not believe that the possibility of a myoma undergoing cancerous degeneration should be an indication for an operation.

Persistent and rapid growth of the tumor is often an indication, especially in a young woman in whom the tumor is growing slightly, but continuously. Cystic degeneration of a myoma is another indication which is apt to occur at the climacteric. Also if the myoma occupies the pelvis, producing pressure symptoms and interfering with the functions of the bladder. Profuse hæmorrhage, causing anæmia and exhausting the patient, undoubtedly indicates a radical operation, after palliative measures have been adopted and failed.

Curettage, followed by packing with iodoform gauze, is exceedingly effective : also dilatation of the uterine cavity and the application of Churchill's tincture of iodine. It must be remembered that subjects of myomata, who have lost much blood and are in a state of chronic hydræmia, are liable to have that condition of heart called brown atrophy ; therefore, in rather young women with copious bleedings and tumors extending to the umbilicus or beyond, it is better to have recourse to a timely operation, rather than to waste time in palliative measures, and then, at last, operate on a patient whose heart is too weak to allow recovery.

A radical operation is indicated when the pains and annoyance that accompany a growing tumor destroy all pleasure in existence, and render the patient incapable of doing any work. Ascites, in consequence of a myoma, can only be relieved by extirpation of the growth, and operation is unconditionally indicated ; as well as in sloughing, suppuration, and telangiectasic degeneration, which are rare events. Olshausen mentions profuse leucorrhœa.

In some cases the complication of pregnancy indicates operative interference. Total vaginal extirpation of the uterus applies especially to cases of subserous and interstitial myomata not exceeding the size of a child's head. When submucous myomata have passed into or through the cervix, remove them by scissors, using Emmet's method of traction. Supravaginal amputation of the uterus or the abdominal total extirpation is indicated in the larger myomata. The after-treatment is more simple after total extirpation than after supravaginal amputation, but it presents greater technical difficulties and demands a greater expenditure of time. —*American Gynecological and Obstetrical Journal*, January, 1898.

DISPLACEMENT OF THE OVARIES IN RETROVERSION AND RETROFLECTION OF THE UTERUS. —(Goldspohn.) The ovaries follow the fundus uteri at close range during all its excursions, unless they are firmly fixed by peritoneal adhesions. Therefore, the ovaries readily follow the fundus uteri in its descent upon the posterior pelvic wall and floor. Being now removed from their retired nooks on the anterior lateral walls of the pelvis, they become subject to

the forces from above, which move them still nearer, when possible, to the median line of the pelvis, back to the retroverted uterus. In this descent the ovaries in most cases become arrested by the sacro uterine folds or ligaments. This is the first degree of descent. They lie, each in a pocket, at the side of the supra-vaginal portion of the cervix and the corpus uteri, where they are readily felt with the vaginal finger in bi-manual palpation. One or both of them may pass over the sacro-uterine folds, and then slip down and forward to the bottom of the Douglass cul-de-sac, behind the cervix, where they are the first thing the finger meets in simple vaginal palpation. This is the second degree of complete descensus, to which the left ovary is most subject.

Pressure, venous stasis or mechanical traumata follow, and we have, as pathological changes in such ovaries :

1st. Hæmatomata in Graafian follicles and corpora lutea.

2d. Œdema.

3d. Connective tissue hyperplasia, which is well known to result from constant embarrassment of the venous current in other organs of the body.

4th. Chronic ovaritis, leading to multiple cystic follicular degeneration, usually in parts of an ovary, and cirrhotic changes in the remaining parts.

5th. Even perioöphoritis, and eventually peritoneal fixation, may occur without infection, according to Säger.

Ovaries that are descended and inflamed require to have restored to them the protection and freedom of an approximately normal habitat as an absolute *sine qua non* to redeem them from destruction.—*American Journal of Obstetrics*, October, 1897.

THE TOXÆMIA OF PREGNANCY.—(Wright.) He is of the opinion that the liver and intestines are mostly at fault ; but that in a certain proportion of cases insufficiency or inefficiency of the kidneys is a serious element in the disturbance, and that the offending toxins are found chiefly in the blood, liver and muscles. The early recognition of the toxæmia of pregnancy is of great importance. The chief symptoms are salivation ; disorders of digestion, with sometimes peculiar taste and constipation ; general malaise ; anæmia ; nervous disturbance, with headache ; disorders of vision ; irritability ; deficient excretion of urine or some of its constituents ; albuminuria. Any sign of the slightest departure from ordinary health during pregnancy should make us suspect the advent of general toxæmia. If, for instance, there be general malaise, with slight headache, but no albumin in the urine, let us not be deceived, since albuminuria is only one of the symptoms of systemic poisoning, and sometimes the last to appear. Its absence proves absolutely nothing.

He does not believe in a strict milk diet. Milk is good in combination with other things ; buttermilk and koumiss are frequently more useful. The following dietary is prescribed : Milk, buttermilk, koumiss, as much as the patients care to drink, no more ; plain water in abundance ; tea once a day, if desired ; cocoa, lemonade, mineral waters, etc. ; stale bread and butter ; dry or cold toast and butter ; rice, tapioca, arrow-root ; fish without rich gravy ; limited amount of white meat and raw oysters ; limited amount of salt ; vegetables of all sorts, restricting the supply of potatoes, and encouraging the use of greens, such as lettuce, spinach, water-cress, etc. ; ripe fruits, such as oranges, bananas and grapes ; other fruits cooked, such as apples, pears and

peaches; mineral waters, especially Hunyadi Janos, or a mixture of Friedrichshall and Carlsbad; milk diluted with such waters, as so-called soda water or Apollinaris or Sprudel or Vichy. Patients are not allowed to take both milk and fish or meat at the same meal. In a limited number of cases eggs, beef, mutton and bacon are allowed; but where the poison appears to injure the kidneys, especially with profuse albuminuria, he prescribes meats of all sorts, eggs and oysters, and prescribes a diet largely composed of diluted milk and vegetables.

*Medical Treatment.*—As soon as symptoms of toxæmia arise, the patient is required to take one half to one ounce of Epsom salts at once, and thereafter two to four drams every hour for two or three doses; an enema is also administered immediately after the first dose of salts is taken, in urgent cases especially, where there is a large amount of albumin in the urine and a small quantity of urea excreted. In less urgent cases a few small doses of calomel, one-quarter grain every half-hour. After six doses are administered, to be followed by the salts. After the bowels are freely opened, smaller doses of salts are given, sufficient to produce not less than four watery evacuations in each and every twenty-four hours. For the first few days he does not object to twelve motions in the twenty-four hours. When the bad symptoms become less severe, he stops the administration of the salts for a time, but he interferes to prevent anything approaching constipation, and desires not less than two evacuations of the bowels every day until after labor. The following prescription is given for a thorough course of free purgation:

R. Magnesii sulphatis, . . . . .	℥ij.
Acidi tartarici, . . . . .	℥iij.
Tincturæ cardamomi compositæ, . . . . .	℥ij.
Aquæ ad, . . . . .	℥iv.

Sig.—A dessertspoonful in hot water t. i. d.

The magnesium sulphate removes a large quantity of serum from the blood, and with it a certain proportion of the circulating toxins, without extracting the blood-corpuscles. It aids the liver and kidneys, which otherwise would soon become seriously diseased from the effects of the poisoning and over-work.

He leaves the kidneys severely alone, excepting so far as the water has a diuretic effect. He desires to have a large amount of water taken into the system. He finds very little benefit from profuse perspiration, but recommends the daily warm bath and woollen fabric next to the skin. He is opposed to the induction of abortion, and, to a less extent, to inducing premature labor.—*Ibid.*

**CANCER OF THE NECK COMPLICATING PREGNANCY AND LABOR.**—(Fehling.) Carcinoma is diagnosed more frequently in pregnancy as women are inclined to come earlier than otherwise for examination and diagnosis. The prognosis is not altogether unfavorable if the operation is performed early. The principal rule is that so long as a carcinoma is operable, the operation should be performed at any time without reference to the child. If the cancer cannot be removed in sound tissue, then attention must be given to the child; and by combining surgical and obstetrical methods far better results are obtained than formerly. The operation for cancer during pregnancy is easier than otherwise, on account of the serous infiltration of the tissues. If the uterus



is too large to be removed by the vagina, then abortion or premature labor should be induced. The uterus is then divided in the median line and immediately removed by the vagina. If the child is large and viable, and cannot be removed by the vagina without injuring the cervix, Cæsarian section should be performed, and followed by complete extirpation of the uterus. Any internal examination should be avoided after making the diagnosis. If the complication is first discovered in labor, the case should be treated as above mentioned; but if the cancer is inoperable, thorough curetting, three incisions in the cervix, and the application of forceps when possible, as version is liable to cause rupture of the uterus. A dead child is to be perforated. A living child which cannot be extracted by the vagina should be delivered by Cæsarian section.—*Ibid.*

A CASE OF EXTRA-UTERINE PREGNANCY, WITH ECLAMPSIA.—Dr. A. Holst was called one evening to a young servant-girl of 23 years, who had been suddenly seized with spasms. Pregnancy had been suspected in the family where she was employed, but she had steadily denied this. The uterus was found, on examination, to be as large as it usually is at the sixth month, and the urine contained a great deal of albumin. Abortion was attempted by injecting hot water into the vagina. The spasms disappeared, and she improved. During the following five months a fluctuating abscess formed, which opened both in the vagina and near the umbilicus, through which little bones were passed. The abscess also communicated with the intestines. On enlarging the abdominal opening the head and the greater portion of the body of a foetus could be extracted. After this, several smaller bones were discharged, and the fistulas gradually closed, and the woman, though greatly emaciated, recovered her health. The writer insists on the rarity of the case.—*Norsk Magazin for Laegevidenskaben*, No. 12, 1897.

THE TREATMENT OF PUERPERAL INFECTION.—(Jewett.) Septic vaginal wounds are to be cleansed once or twice daily and touched with tincture of iodine, or with a 50 per cent. carbolic or chloride of zinc solution. They may then be dusted with iodoform, or a strip of iodoform gauze may be left in the vagina to keep the walls apart.

Lacerations extending into the broad ligament should be cleared of blood-clots and packed with iodoform gauze. Vaginal douching is useful in the presence of foul discharges. He recommends the peroxide of hydrogen or a 1 in 10 Labarraque solution. No active interference within the uterus should be undertaken until assured that it is involved in the septic process. Tardy involution and an abnormally gaping cervix are presumptive evidence of a septic or putrid endometritis. Notwithstanding the fact that the germicidal effect of the irrigant does not extend into the tissues, a suitable antiseptic has the advantage that it destroys putrid and putrescible fluids in the uterus.

While the curette and the douche regionally employed are valuable resources in the treatment of puerperal septic endometritis, their empirical use as routine measures has done incalculable harm; and curetting is not to be lightly undertaken by men who are untrained in surgical work. Extension to the para or perimetrium does not forbid intra-uterine measures; it rather demands the more urgently that the primary focus of infection be abated. The curette is contraindicated in the absence of debris in the uterine cavity.

In purely septic, as distinguished from sapremic, infection of the endo-

metrium, painting the entire cavity of the uterus with tincture of iodine or with a 50 per cent. carbolic or iodized phenol solution has in many cases done great service. The uterus is first washed out by prolonged irrigation with normal salt solution or with a mild antiseptic; finally a loose packing of iodoform gauze is left within the cavity, to be removed in twenty-four hours. Iodoform crayons are excellent substitutes for the gauze, each crayon containing 10 grains of iodoform in an excipient of glycerine and gum tragacanth. From two to six pencils are placed at the fundus. Little or no benefit is to be derived from local measures in purulent forms of infection.

Intrauterine irrigation is of little value except to wash away dead animal matter lying free in the uterine cavity. Repeated douching is frequently injurious; it is permissible only so long as the temperature calls for it. Alcohol, to realize its best effects, should be pushed to the point of intoxication; the maximum daily dose may be one quart of brandy, or its equivalent. Whiskey, brandy and wines should be used in alternation. Strychnia in doses of  $\frac{1}{30}$  of a grain from three to six times daily according to the degree of exhaustion and the tolerance of the patient, and quinine in tonic doses of 3 or 4 grains every six or eight hours, are most useful. Food must be given in small quantities and often; water drunk as freely as can be borne; abundance of fresh air; these tend to promote elimination of diseased products.

Wilischianin has shown by experiments on animals that the quantity of septic poison required to intoxicate is doubled or tripled when the animal drinks abundantly. Simple alkaline waters are useful; cold bathing judiciously employed has the effect of a nerve tonic; cold sponging is indicated when the temperature is 102° F. or higher; the circulation is maintained by friction and by warm applications to the extremities. In the presence of depression of the vital powers, refrigerant measures are contraindicated.

The serum treatment of puerperal sepsis is still under trial, and its statistics thus far are not conclusive. The dose employed is varied from 10 to 120 cc. per day.—*American Gynecological and Obstetrical Journal*, November, 1897.

**SACCUATION OF THE PREGNANT UTERUS FOLLOWING VENTRO-FIXATION.**  
—Dr. Lucia E. Heaton, Canton, N. Y., reports the following case of a well-nourished woman, aged thirty-one, the mother of one ten-year-old child, who had been operated in 1893 for prolapsus, ventro-fixation having been performed. The doctor saw her in January, 1896. A vaginal examination was made with the following result. The fundus of the uterus was firmly attached to the abdominal wall; the cervix rested against the pubis with the os a little above the meatus urinarius; marked systocele, due to forcing down of the anterior vaginal wall with the bladder. The patient became pregnant in March, 1896, and fearing that the fundus would not rise with advancing pregnancy, Dr. J. N. Bassett was called in for advice. The fœtus was persistently in the transverse position, but freely movable, though the fundus uteri never rose above the umbilicus. The pregnancy was progressing so favorably that it was thought best not to interfere.

Labor began December 29th, but subsided in an hour or two. At four A.M. of the following day pains began again, but soon subsided. At five P.M. pains resumed and continued until midnight, when the membranes ruptured. The os was undilated and the presenting part too high to reach. The child was strong and freely movable. The mother was tired, and the pains, which had



never been strong, were failing. Dr. Bassett was then called, and after consultation it was decided to let the mother rest. This was done, and labor interrupted until four o'clock next day. Labor was then resumed, with better pains than at any time before. The os was slow to dilate, so forced delivery was decided upon. This was accomplished under chloroform anæsthesia.

The following is the condition found by Dr. Bassett within the uterus: The os was found high in the pelvis, and dilated about the size of a twenty-five-cent piece. The os was dilated with the fingers, and the hand gradually passed through the vagina and dilated os into the womb. He says, "I could feel no presenting part; apparently the child was in front, and separated from my hand by a mass of muscular tissue as thick as the abdominal wall. I continued to pass my hand up until I found the head, the presenting part, in the right hypochondriac region. Further exploration found the child in a large anterior sack or bag of the uterus. I thus had the head of the child in a small posterior sack and the body of the child in a large anterior sack, the neck of the child lying over the edge of the sack as over a shelf. After various efforts to change the position and get the body from the large anterior sack, I pushed the head across the abdomen to the left hypochondriac region, pushed the body of the child to the right side of the mother, and by long-continued traction on the shelf-like fold slipped it over the fundus of the child. The head readily came into position at the brim of the pelvis. Delivery was accomplished by forceps."

The child was dead. The mother was in a condition of shock for six hours following delivery, but afterward made an uninterrupted recovery.—*The American Gynec. and Obstet. Journal*, 1897.

**A NEW INCISION FOR CÆSARIAN SECTION.**—Fritsch recommends an incision across the fundus of the uterus. He believes there is less danger of hernia afterwards. The abdominal walls can be thoroughly compressed. The operation is very neat and cleanly, as the blood does not enter the abdominal cavity, but is readily wiped aside or escapes externally during compression. The hæmorrhago itself he believes to be less than by the older method. The womb diminishes very rapidly from the contraction of the fundus, the line of incision being parallel with the vessels instead of at right angles as in the older method.

This method has been tried by other operators since the publication of this article, and has not been found to merit the praises given to it by Fritsch.—*Centralblatt für Gynäkologie*, No. 20.

**SIGNS AND SYMPTOMS OF BEGINNING PREGNANCY.**—(Vinay.) In most women pregnancy can be ascertained with reasonable certainty from the sixth to the tenth week, particularly in uteri slightly anteverted. He considers Hegar's sign very valuable when found, but it is not constant. The difference in form and consistence of the two uterine segments is of fundamental importance. While the cervix retains its cylindrical and more or less elongated form, the corpus becomes spherical and enlarges in all its diameters, particularly in transverse direction. On the other hand the softening of the column proceeds gradually from below upwards; the orifice retains for a long time its normal consistence to the touch, while the corpus undergoes early important alterations in consistence. The walls become softer, heavy, fluctuating, and can be pressed



in by the finger. It is this difference which he finds of especial importance in the diagnosis of early pregnancy.—*Ibid.*

GEORGE R. SOUTHWICK, M.D.

TREATMENT OF RETROPOSITIONS OF UTERI.—Dr. J. R. Nilson, New York, places his chief reliance upon direct local measures, chief of which is the pessary. Besides this, various agents applied to the vaginal vault by tampons, prolonged douches, massage, postures, curettage, etc.

The reposition should be bimanual where it is possible. If this method is not attainable he uses a large sound, being careful to disinfect it thoroughly.

Regarding the use of the pessary, he says: "Be sure to make the first pessary long enough, with very slight curve. In fact, where the reposition has been at all resisted, and thereby suggesting the possibility of the uterus falling backward again, I make the first pessary straight, or almost so, except at the lower end, which is always more or less curved. Then, should the uterus fall backward, the posterior bar of the pessary will not receive it in a manner to cause or increase a flexure. I work from the straight toward the curved, never from the sharply curved, sharp pessary, down to the straight. I know of few things giving greater scope for ingenuity, aided by sound reasoning, than the use of the pessary; and it is not a little remarkable how slight an alteration in a pessary curve will have a decided effect upon the uterus and be noticed by the patient." He advises daily irrigations of lukewarm salt water with a hand-bulb syringe to keep the pessary clean. This syringe is better than a fountain syringe for this purpose, as it gives more force to a number of small cutting streams.—*Am. Gynec. and Obstet. Journal.*

WOODWARD D. CARTER, M.D.

SLIGHT ERRORS OF REFRACTION AS A CAUSE OF DISCOMFORT AND DISEASE.—"1. The trouble resulting from low degrees of ametropia is reflex in character, and involves the central nervous system.

"2. This trouble is disproportionate to the prime cause, and its severity depends upon the susceptibility of the individual nervous system.

"3. Anything which lowers the resisting power of the nervous system, or which increases the irritation of the ocular defect, tends to increase it.

"4. Eye-strain is the beginning of the trouble, which may be asthenopic, accommodative or muscular, or may assume slight inflammatory forms.

"5. This strain is a result of interference with the harmony of accommodation and convergence.

"6. Its importance is due to the complexity of the visual act and its intimate relation to the whole nervous system.

"7. Its results may be far-reaching, and it forms one of the principal factors in the ætiology of headache.

"8. Exact diagnosis, by a reliable objective examination, is of the utmost importance, and should rarely be made without the aid of a mydriatic."—Gillard S. Tennent, M.D., *The Charlotte Med. Jour.*, January, 1898.

EAR MANIFESTATIONS IN GENERAL DISEASES.—Dr. Wendell C. Phillips, of New York, in a paper on this subject, spoke of the rather puzzling ear symptoms often observed in traumatic cases, and of the very common neglect of these cases.

That they were important was shown only too plainly in later life, when they come under the care of the aurist, and also by the fact that certain of our large life insurance companies refuse to accept as good risks persons who give a history of chronic suppuration of the ear. An earnest plea is made for better care of the ears by the general practitioner, particularly during the course of scarlet fever and other exanthemata.—*Med. Review of Reviews*, February, 1898.

**THE MUCH-ABUSED NOSE.**—"Understand its structure, and do not do anything blindly or without good reason.

"Always make a careful anterior and posterior rhinoscopic examination, and do not accept a snap diagnosis.

"Always clean the nose, and don't allow the patient to go with it unclean.

"Give him definite instructions and methods of procedure, and don't take for granted that he knows how to use a douche; but tell him what to use, and don't allow home remedies like salt water or Pond's extract.

"Pay attention to the general health, and don't forget that the nose is an integral part of the system, not a thing apart from it.

"Pay personal attention to the patient and each detail of treatment. Don't trust him too much.

"Recognize the principles of successful surgery, and don't cut, saw and burn indiscriminately.

"Examine each case to see if the calibre of the canal is diminished and if there is obstructed breathing, and don't fail to correct it by surgical means.

"Remember the dangers of prolonged mouth-breathing, both as to liability of infectious disease, lack of power to resist disease, and tendency to pulmonary complications, and don't allow adenoids to go unrelieved in the hopes that the patient will grow out of it.

"Remember the failings of the human race, and don't forget the possibility of syphilis even in ministers, deacons, or the lights of society.

"Use knowledge, science and skill in treating the nose, and don't forget to use common sense."—Dr. F. T. Rogers, *Atlantic Medical Weekly*, January 29, 1898.

**IN SEVERE EPISTAXIS**, when plugging the nares, anterior and posterior, a very important part of the procedure is to saturate the cotton used for plugs with alboline, liquid vaseline, or any light oil, to prevent the blood oozing through.

**IODIDE OF POTASSIUM IN CATARACT.**—Pagenstecher recommends the method of v. Arlt, brought forward twenty-three years ago, of using iodide of potassium ointment about the eye in beginning cataract.

He has used it in many cases, and has no doubt that it can bring the cataractous process, especially the different forms of opacities, to a standstill, and in some cases increase the vision.—*Klin. Mon. f. Augenhkde*, Dec., 1897.

**THE INFLUENCE OF PROPER ILLUMINATION UPON ACUITY OF VISION AND THE DEVELOPMENT OF MYOPIA.**—Seggel considers the various causes of myopia, and gives tables indicating the development of myopia in schools,

showing that the percentage of myopia in higher classes rises progressively, both as to those pupils who are myopic when entering school, and those who develop it during the course. He shows, further, that the condition of myopia exists not only in schools frequented by the better classes, but also in the village schools, and that with the myopic condition acuity of vision suffers likewise.

A statistical study of the myopes found in schools at present as compared with those of years ago prove that acuity of vision has improved in all classes, and this is attributed to the better hygienic condition existing in schools, with special reference to the improved facilities for natural and artificial light.—*Munch. Med. Woch.*, Nos. 38 and 39, 1897.

**NATURE OF VERNAL CONJUNCTIVITIS.**—G. Schleich has made special observations regarding the general condition in cases of spring catarrh of the conjunctiva. In ten cases he invariably found a general swelling of the lymph glands, polyadenitis, and observed that these patients were always pale and anæmic.

In one case he found an enlargement of the spleen.

In nine cases out of ten, examination of the blood shows increase of the white blood-corpuscles in comparison to the red.

It is, however, to be remarked, that only in one case a thorough count of the blood-corpuscles was made, although in the remaining cases the total amount was estimated in the manner in which blood examinations are usually made in daily practice. Re-examination of these findings with more thorough examination of the blood-corpuscles is to be desired.—*Festsch. des Stuttgarter Arztl. Vereins Stuttgart*, 1897.

**POTASSIUM PERMANGANATE IN OPHTHALMIA.**—Mr. Sydney Stephenson, London, Eng., communicated particulars of a case of purulent ophthalmia in a baby where the frequent use of a strong solution of potassium permanganate had given rise to a deposition of manganese dioxide upon the cornea. The mark, which was of coal-black color, disappeared in a few days, after the use of the solution had been discontinued.—*British Medical Journal*, Nov. 20, 1897.

**CASES OF OPHTHALMIA NEONATORUM.**—A report of fourteen cases of this disease was made with the object of showing that by careful examination of the discharge from the eyes a great many cases were not due to gonorrhœa. He noticed, also, that when gonococci were found in the discharges, the discharge lasted longer and was much more difficult to treat.

In some cases in which no gonococci were found, the disease had been made worse by improper treatment, and got well rapidly under milder means. In making his diagnosis with the aid of the microscope, he depends not only upon the shape and size of the diplococci and the fact that they are inside the cell surrounding the nucleus, or inside of the pus-cells, but chiefly on their not taking on staining by the Gramm method, since there are quite a number of diplococci that are nearly of the same size and shape, which are sometimes found inside the cell surrounding the nucleus, by accident or otherwise; but all such diplococci are stained by the Gramm method, while the gonococci are not. F. T. Reiling, M.D.—*Amer. Jour. of Ophthalmology*, October, 1897.

WM. SPENCER, M.D.



## MONTHLY RETROSPECT

### OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

---

**ACONITE AND INFLUENZA.**—M' Lachlan, discussing the claims of this medicine to a place in the therapeutics of influenza, directs attention to Hahnemann's introduction in the *Materia Medica Pura*. There is one group of symptoms so characteristic of aconite that Hahnemann said: "Aconite should not be given in any case which does not present a similar group of symptoms." These are the symptoms of the mind and disposition, viz., "Restlessness, anxiety and uneasiness of mind and body, causing tossing and sighing and frequent change of posture; forebodings, anticipations of evil, anguish of mind, dread of death, and even distinct anticipations of its occurrence."

Now aconite does not seem to have any effect on organic substance—does not produce any marked or characteristic change in the tissues or fluids of the body, and it cannot therefore in itself be sufficient to carry a patient safely through a complete course of pure acute inflammation of any organ or system. The only modification to the above statement is in the case of measles, where, so far as the writer's experience goes, aconite is usually in itself quite competent to do all that is needed to be done.

In the action of aconite that localization is wanting which is the essential feature of these inflammations. Its great use in such cases is in the very early stage of the inflammation, *i.e.*, in the stage of general arterial excitement which precedes its localization in any one organ or tissue, and therefore even before the "active hyperæmia" stage and long before the stage of exudation. It must never be given merely to "subdue the fever," and then some other remedy added to "meet the case;" nor is it to be alternated with other drugs for the purpose of "controlling fever." If the fever be such as to require aconite, then no other drug is needed, and if other drugs seem indicated one should be sought which meets the fever as well, for each drug has a fever after its kind.

There is no resemblance in the pathogenetic symptoms of aconite to the features of any dyscrasia, and for this reason it can never be required in any of the miasmatic fevers or dyscratic diseases—save perhaps as a rare and temporary intercurrent in some complication, or where the group of symptoms of the mind and disposition are present. Its action bears no resemblance to that of any poison, such as that which produces typhus or typhoid, intermittent or remittent or continued fevers. Our allopathic friends even have discovered that aconite is "good for fever," and they have tried it in such fevers as typhoid with no beneficial result on the death-rate of that disease. Some of our own men, with a total misunderstanding of the essential inner nature of the pathogenesis of aconite, and led away by a few unimportant and superficial similarities, have even recommended its use in "ulcerative endocarditis."

What then is its use in an epidemic of influenza? It can hardly be of use in genuine influenza; but it is of great use in those cases where one is in doubt whether the symptoms manifested are the result of a simple chill or of the specific poison of influenza. A few doses of aconite 30 will speedily banish all doubt; for if the case is the result of a simple chill and can be taken sufficiently early aconite will be all sufficient to effect a cure, but if due to the poison of influenza it will have no beneficial effect and some other remedy will have to be given.—*Monthly Hom. Review*, March 1, 1898.

FRAGMENTA.—Under this heading, Dr. C. S. Middleton reports the following uses of drugs:

*Absinthium* has often brought more or less sleep in typhoid fever when in that serious disease wakefulness has been a prominent and menacing symptom, due perhaps to nervous exhaustion and hyperæmia of the brain. So also has absinthium proved useful in allaying the nervousness excitement and sleeplessness in children when other drugs have either failed or not been indicated.

*Antipyrin*.—Some one a long while since, in Boericke's *Recorder*, advised the use of this drug, in the 6x trituration, in high and apparently dangerous temperatures, and stated that a reduction of the heat would surely follow. This result has followed its use in my hands in all the instances in which it was applied. I have never used antipyrin in massive doses, but rarely in the above potency, in which form it can scarcely be said to do harm; on the contrary, benefit followed.

*Arsenite of Copper*.—Dr. W. C. Goodno is high in his praise of this drug in Bright's disease when uræmic convulsions are present and the usual diminution of urea excreted. Cup. ars. has benefited some of my cases in the latter condition, especially where there was headache before convulsions had appeared. Since using this drug I have not had a case of convulsions.

*Berb. vulg.* has often relieved "backache" where it is not always easy to ascertain whether the trouble may be congestion of the kidneys or a muscular *ennui*. This was one of the late Dr. McClatchey's remedies for that purpose.

*Borax*.—Hahnemann says, in his *Chronic Diseases*, that the use of borax has been known to facilitate conception. Of this the writer thinks he has proof in one instance. He attempted to institute a series of experiments upon "fallow" cows by administering it in a food prepared especially for such, but, as the party failed to carry out the project, it was abandoned.

*Calc. iod.* has proved a most excellent remedy in the enlarged cervical glands of strumous subjects.

*Cann. ind.* is often of great benefit in "renal colic." It also cured a cough, incessant, with raising of vast quantities of frothy mucus.

*Cann. sat.* relieves the sudden and almost irresistible desire to urinate in certain cases, and especially in gonorrhœal urethritis.

*Capsicum*.—The capsicum sore throat is very red and much infiltrated, with almost incessant tickling at the top of the larynx, and hoarseness.

*Carbolic acid* is an excellent remedy for a form of indigestion (dyspepsia) accompanied with eructations, with or without weight or heaviness at the epigastrium. It is also very effective in counteracting the scarlatina poison, but does not seem to be of service in diphtheria. Used in the 1x dilution (freely) in water, carbolic acid will cure small-pox, *i.e.*, get the eruption out, and carbolic acid will prevent pustulation and secondary fever. (See *Hahnemannian Monthly*, April, 1872, and Hale's *New Remedies*, 3d edition.)

*Erigeron can.* has proved very valuable in my hands in hæmorrhages of all kinds, from the mouth, to uterus, blood bright and free; used in tinct.

*Eryng. aquat.*, in tincture, 5- to 20-drop doses, four to eight hours, has cured many cases of gonorrhœa for me.

*Gelsemium.*—It would be impossible to enumerate the many indications for gels. I want to call attention to the great good it will do in sleeplessness, when there is great activity of the mind; thoughts flying from one subject to another, due, of course, to too much circulation of the blood in the brain for sleep to come.

*Gnaphalium* has cured sciatica when, with the severe pain, there is numbness in the limb.

*Gratiola* will cure diarrhœas with characteristics very similar to those of Croton tig., but where that drug may have failed, and where the pain of croton is absent—but other symptoms present.

*Hyoscinamine hydrobom.*—This drug is used largely, I believe, by the old school in insomnia of the insane. It is a powerful poison. It has never proven very satisfactory in my hands for sleeplessness. It should be used with great care. The 3x trit. has been very useful in nervous excitement and a state bordering on paralysis agitans, after the excessive use of alcohol, tobacco, etc. In highly excitable or nervous children who are easily frightened it has been of service. I have used it in dilution also much higher than the 3x.

*Iodine* will cure more cases of laryngitis and croup than any other one drug, used in 1x dilution at short intervals when case is severe. Indications: soreness, hoarseness, dry barking, crowing cough, difficulty of breathing and scanty or no expectoration. It seems to act as well in children of either temperament or complexion.

*Kali chlor.*, according to Schuessler, has proved very valuable in glandular swellings in strumous subjects, even after scarlet fever.

*Macrotin.*—The active principle of cimicifuga rac. will relieve congestive headaches at the base of the brain, and where uterine congestion is also present, and perhaps some rheumatic symptoms besides. 1x to 3x trit.

*Merc. vin. iod.*—I believe, to get the best result from this drug in diphtheria, it is often necessary, where indicated, to give it in large doses. The writer uses the 2x trit., and often finds it necessary to use as much as 5-grain doses, frequently repeated.

*Rhus rad.* will cure certain forms of basilar headaches, especially where the pain radiates up the left side of the head and face. If muscular rheumatism is present the rhus rad. will be still further indicated. Dr. Korndorfer first called my attention to the above facts. It has been successful in the 6x.

*Taraxacum*, fl. ex., has cured gastralgia when inactivity of the liver has been the factor in the case. Also jaundice, with intense itching dry skin, where probably the gall duct has been partially obstructed, and the biliary glands congested. It is a favorite remedy with me in such cases.

*Terbinth.* in 5-drop doses on brown sugar, has apparently saved more than one life for me in hæmorrhage of the bowels in typhoid fever. Blood dark, grumous and offensive; undoubted ulceration on the verge of perforation; a dose after each hæmorrhage. Hæmorrhage from the kidneys in post scarlatinal, Bright's. I find it a most excellent remedy in some cases of chronic gonorrhœa or gleet.—*Transactions Pa. State Homœopathic Medical Society*, 1897.



**GLONOINE IN HEMOPTYSIS.**—In the issue of the *Philadelphia Medical Journal* for February 19, 1898, appears an article by Lawrence F. Flick, M.D., in which he advises the use of nitro-glycerine for hemoptysis, citing several cases of relief from the use of the drug. He claims that the rationale of the action of the drug in these cases is, that hæmorrhage is caused by "constriction of the blood-vessels and too great force from behind." This being an assumed fact, he gives nitro-glycerine to cause dilatation, and hence his cases are relieved—antipathically. The *American Medical Monthly* (April, 1898), however, takes exception to Dr. Flick's explanation of the cause of hæmorrhage. Hæmorrhage is usually preceded by congestion, and congestion certainly is caused by too much blood in the capillaries. Hence, hæmorrhage is caused by too great dilatation of the capillaries, not from too much constriction, and as nitro-glycerine when given under ordinary circumstances causes dilatation of the capillaries also, it follows that when nitro-glycerine is given for hemoptysis its curative action is in accordance with the law of similars. Why the drug will cure dilatation of the capillaries when it will produce similar dilatation in the normal organism is, perhaps, somewhat difficult to explain (several theories have been advanced), but that such is the fact these cases reported in the *Philadelphia Medical Journal* attest.

**PICRIC ACID IN DISEASES OF THE NERVOUS SYSTEM.**—Kinney, of the Middletown State Homœopathic Hospital, contributes to the *State Hospitals' Bulletin* an exhaustive study of melancholia and its treatment. Little new in the homœopathic therapeutics is suggested. Of picric acid he remarks that the remedy has not been thoroughly proven as yet, but so far it has been found to cause, when taken in poisonous doses, disintegration of the blood corpuscles and softening and disintegration of the cortex cerebri, cerebellum, medulla oblongata and spinal cord, and consequent paralysis. It also produces inflammation of the kidneys, loading the urine with phosphates, urates and uric acid. Albumin and sugar are likewise found in the urine. In smaller doses there is at first congestion, which may vary from a feeling of fatigue to actual paralysis. Associated with this is a mental inactivity, lack of will-power, indifference to everything and a desire to lie down and rest, thus simulating brain-fag, neurasthenia and sexual exhaustion, in which conditions is found its chief sphere of usefulness. The mental symptoms are those of great indifference to everything, lack of will-power, disinclination for mental or physical work, and prostration on attempting any mental effort.—*Medical Century*, April 1, 1898.

**THE CHARACTERISTICS OF PSORINUM.**—Young, of Buffalo, reviews the provings of psorinum, and as a generalization notes that the psorinum individual looks dirty, his skin is dingy, yellow, often oily and coarse; there may be herpetic eruptions or their remains upon it, especially on the forehead, chest, and in the bends of the joints. He is emaciated, yet has a great hunger, but with no appetite for his food. In addition, he sweats profusely all over the body, especially at night, or on the least exertion, and the body, despite persistent washings, emits a most foul odor. These persons are usually affected by stormy weather, and are weak and tired all the time.

The remedy has been used most often in cases of great and stubborn debility following severe diseases, where we can find no organic trouble remaining, in just the condition where so many use tonics from ignorance of something

better to do. Psorinum has a most remarkable power in these conditions to restore the depressed vital force. In such cases we find the patients depressed in mind as well as body; they are low-spirited, hopeless of recovery, the memory is weak, and with their depressed condition they are inclined to be cross and irritable. With this they have the profuse sweats at night, the foul odor of body, the black, horribly offensive stools, and the dirty, oily, emaciated appearance.—*Medical Century*, April 1, 1898.

**THE BOWEL SYMPTOMS OF PSORINUM.**—According to Young, the bowel symptoms of psorinum are of the utmost value and clearness. There are dark brown or black, horribly offensive watery movements. These are nearly painless. They occur usually only at night or toward early morning. Bell says that "though the dark color is very characteristic of the remedy, the unparalleled odor is more so;" and he says that where that occurs in a case, whatever the stool may be like, a favorable change will usually follow the administration of psorinum.

These symptoms may be compared with those of leptandrin, which also has a black fluid stool. It is offensive, but less so than that of psorinum, and it is apt to be more faecal than watery. But it is accompanied, and especially followed, by severe cramps and colic, which is very unlike psorinum. There are none of the characteristic general symptoms of psorinum.

Asafœtida has a horribly offensive stool, but it is not black; is painful, and the general symptoms are unlike. Arsenicum also has a black, foul stool, but it is small, painful, acrid, and the general symptoms again make the difference. Under squills there is a black, fluid, offensive, painless stool, seemingly just like psorinum, but, on closer comparison, we find that they are also frothy, and there is an absence of the characteristic psorinum debility.—*Medical Century*, April 1, 1898.

**THE DIFFERENTIATION OF MEZEREUM FROM MERCURIUS.**—According to Hanchett, one of the great distinctions between these two drugs is found in the character of the skin eruptions. The mercurial eruptions are generally flat and of a dark copperish color, while the mezereum eruptions are more like vesicles coming to a head, and apt to be white at the apex. The copper color he sometimes noticed about the base in the form of a little circle. When the vesicle would break, it would simply leave a thin scab and disappear without the dark-colored coppery appearance. The condition of mind is not the deep gloom and morose disposition of mercurius. Another characteristic appearance is that the mercury patient may sweat freely but is not relieved by the perspiration, while the mezereum patient is usually relieved by perspiration. The mezereum perspiration is not of that peculiar sticky and clammy character which is so commonly seen in mercurius. Moreover, while mercury produces many skin affections, they are generally of a secondary stage; mezereum often primarily affects the skin surfaces. Mezereum may be classed among the skin remedies. It has cured shingles and pityriasis. It causes intolerable itching and irritation of the skin, and it also irritates the genito-urinary organs much as cantharides does. Mercurius has a similar action, but the acrid discharge of mercurius seems to come from a deep ulceration of the mucous surface, and not the general or diffuse inflammation to which mezereum is adapted.—*Medical Era*, April, 1898.

F. MORTIMER LAWRENCE, M.D.

# THE HAHNEMANNIAN MONTHLY.

---

JUNE, 1898.

---

## THE PREPARATORY EDUCATIONAL NEEDS OF THE AMERICAN MEDICAL STUDENT.

BY PEMBERTON DUDLEY, M.D., PHILADELPHIA.

Dean of the Hahnemann Medical College of Philadelphia.

MORE than almost any other vocation, the practice of medicine forces every proposition it encounters to the test of utility. So exact is the knowledge which this vocation demands, so exclusively material the agencies it employs, and so vital the interests it conserves, that it never hesitates to sacrifice the merely ornamental and theoretical to the practical and useful. Even the subject of education—and no matter whether preparatory or professional—the tendency of its more practical and progressive spirits is to discount, if not altogether to discredit, every subject not directly concerned in the efficiency and success of the practitioner. This tendency is nowhere more marked than among those engaged in the work of medical education, and who have opportunities for observing the student's necessity for husbanding his gold, and—what is even more precious—his time.

In recent years new rules, regulations and requirements are being enacted by societies, school authorities and licensing boards, for the purpose of improving the preliminary educa-



tional status of those entering the medical colleges. The schedules of "Requirements" issued by these bodies exhibit a remarkable uniformity in just one particular; *i.e.*, each and every one of them is unlike any one of the others. They also exhibit certain other interesting features. For example, one State licensing board demands a certain specified knowledge of algebra—a subject for which neither the student nor the physician ever has any use—but makes no demand for an acquaintance with mensuration, for which they have very frequent use. Another State licensing authority exacts proficiency in political and statistical geography—for which the study and practice of medicine make no demand—but satisfies itself with a mere "outline" of physical geography—a department of the subject which is in frequent requisition. One schedule of requirements includes Latin; another both Latin and Greek, and a third neither of these two branches. One college distinguishes itself by requiring botany, zoology, and mineralogy. A certain renowned institution lays down a course of elective readings for the prospective medical student, at one part of which course he is permitted to make choice between Tyndall on *Heat as a Mode of Motion* and George Eliot's *Middlemarch*. And we might add numerous others.

These peculiarities of the schedules of requirements for admission to our medical schools have two explanations. *First*, there is an assumption in the minds of those who give direction to our general education, and in the minds of many physicians as well, that what is known as "a good general education" constitutes both a sufficient and a proper preliminary requirement for a student of medicine. *Second*, the schedules prepared by the medical licensing boards, always as a matter of presumption and usually as a matter of fact, exclude the suggestions dictated by the experience of medical educators, and rarely, if ever, represent the advance sentiment and opinion of those who are presumed to possess the wisest judgment on such matters. (This defect in the enactment of these rules arises from the fact that men engaged in medical teaching are by law ineligible for service on these boards.)

It is evident, then, that the subject of the preparatory education of medical students requires a thorough and careful revision. Any wise discussion of the theme must have constant reference

to three factors: *First*, the educational condition of our American life, out of which the profession of medicine is to be recruited. *Second*, the opportunities and capabilities of those who volunteer to enter it. *Third*, the law of supply and demand as affecting the number, and indirectly the quality, of the physicians to be educated.

The public—which the Commonwealth is presumed to represent—demands physicians sufficiently skilled to properly care for the sick and injured, and in sufficient numbers to meet the necessities of the whole population; and that is all. The Commonwealth does not ask whether her physicians are fitted to shine in the circles of polished society, nor whether they are possessed of a high degree of literary culture, nor whether they are financially prosperous, nor whether their numbers should be reduced for the sake of those who may chance to escape the trades-union process; she asks only for a sufficient supply of competent physicians. It is the only question she has any legitimate business to ask on the subject.

But the medical colleges, dependent as they are upon the fees of their students and not upon contributions or other support from the State, have an undoubted right to ask more. Their renown, and incidentally their prosperity, depend largely upon the educational status of their alumni, as well as upon their professional competency. Hence the colleges themselves have a peculiar problem to solve in reference to the preparatory education of their matriculates.

Writers and speakers on the subject have reached two conclusions respecting the minimum requirements for admission to a medical college. One is that all of them should be required to possess a degree in arts, science or philosophy; and the other—less exacting—that they should be required to pass an examination similar in all respects to the entrance examinations of our best literary colleges. The reasons assigned for these requirements are rather unspecific in character, and appear to have reference to the general needs of professional and other well-educated people, rather than to any specific needs of the physician in particular. One reason assigned for insisting on the Bachelor's degree as a prerequisite to medical study is that the medical man should be required to possess as good an education as the clergyman or the lawyer. This reason is

faulty in two particulars: it misconceives the facts and it begs the question. And the whole proposition is defective, in that it utterly ignores the fact that the duties of the medical practitioner are absolutely and altogether unlike those of his brethren in the other professions. As for the implied intimation that physicians do not possess *as much* education as their fellows at the bar or in the pulpit, it is possible that our critics may have mistaken quantity for quality, and *vice versa*.

Between medicine on the one side and divinity or law on the other there is a gulf as wide and deep as the chasm which separates thought and matter. Their spheres of activity touch each other at certain points, it is true, but that is all. Their practitioners labor in distinct fields, they use different instrumentalities, they employ different forces, their operations are conducted under the influence of different laws, and they seek the accomplishment of objects and purposes as unparalleled as any dissimilars that the human imagination can conceive. The one sweeps the vast firmament of thought and motive and conduct, of passion and imagination; the other patiently searches out the secrets of the world of matter. One deals with the abstract, the other with the concrete. One occupies the domain of man's intellectual and moral nature, the other toils amid the materials which compose his bodily organism. And when it is proposed that the representatives of professions whose work and purpose, whose agencies and methods and guiding principles are so radically—so absolutely and entirely—dissimilar, still need the same education preparatory to their professional training, the burden of proof must rest upon those who offer it. The proof has not yet been presented.

There are at present in the United States probably not less than one hundred and fifteen thousand physicians. Polk's *Directory* gave the names and addresses of over one hundred and six thousand in 1896. Estimating our present population at seventy millions, this will allow one physician to each six hundred people, or one hundred and twenty families. The *Directory* just mentioned shows that the physicians of most of our large cities attend a smaller number than this national average. We must infer, therefore, that those who practice in the country and smaller cities and towns attend the full average of patients, *i.e.*, about six hundred each. Those who are in the habit



of saying that the medical profession is overcrowded base the statement on a comparison with the number of practitioners of European countries, forgetting the greater needs of our more sparsely settled communities. In many portions of our country physicians are obliged to compass a radius of twenty, thirty or fifty miles in all directions, and I have recently received a letter from a correspondent in the West who complains that her husband's nearest brother physician is a hundred and seventy-five miles distant. In all our large cities there are certainly twice as many physicians as there is need of, but in the country at large it is very doubtful if the profession is more overcrowded than nearly all other vocations are said to be.

It has been recently shown that the average age at which American physicians die is fifty-six years. According to the lists of names and ages of the graduates of all the twenty homœopathic colleges in the United States, published by the American Institute of Homœopathy from year to year, it appears that the average age at which medical men begin practice is over twenty-eight years, thus leaving, as the average period of actual practice, less than twenty-eight years. This signifies that the whole medical profession must be practically renewed once every twenty-eight years, or that more than forty-two hundred physicians must be graduated annually. This number makes no allowance for the annual increase of population—an increase which swells the total annual requirement to forty-four hundred, not counting those medical graduates who take up the practice of dentistry and veterinary medicine, and the still larger number who, for the same causes as those which affect other people, change to other lines of business. We probably need about forty-seven or forty-eight hundred medical graduates per annum. We are actually graduating about two hundred in excess of that number.

Now, where shall we get these forty-eight hundred medical recruits? "From among the graduates of our literary colleges," says one. It would take every bachelor of arts in the country, and still leave us lacking; it would consume three-fourths of all the bachelors of arts and of science combined. But suppose these literary graduates have no taste for the practice of medicine, and do not wish to enter the profession. The last published *Address-Book* of Brown University shows that,

of her graduates, those who adopt medicine as a profession do not exceed 9 per cent. It is probable that a similar proportion will be observed in our literary schools generally. Is this at all surprising? Is it not reasonable to suppose that the intellectual tastes which attract young men to the study of classical literature and to philosophy—to history and poetry and ethics and economics—would almost repel them from medicine? Remembering the potency of intellectual taste in determining the choice of a profession, is it astonishing that medicine obtains so few accessions from among the graduates of literary schools?

But the reply will be made that those who do contemplate a medical career shall simply be required to procure a literary collegiate education first. Those who have made this suggestion have, in nearly all instances, made the serious mistake of assuming that medical students, as a rule, step directly from the elementary or secondary school into the medical college. How erroneous this assumption is can be seen by reference to a fact already cited, namely, that the average of medical graduation is over twenty-eight years; in other words, that students enter the medical schools at the average of twenty-five years. How have they spent the eleven years since they left the grammar school? Not in the higher schools, we may be very sure. The majority have been engaged in various lines of business, earning the means wherewith to purchase a professional education. Now it is proposed that these students shall also be required to earn the means to purchase a literary collegiate education, and then spend four years in acquiring it—a total of eight or ten years more, to be added to the twenty-eight at which they would otherwise have graduated. We are aware that certain of our educational authorities have estimated that it is possible for a school-boy, after leaving the grammar school at fourteen years of age, to acquire a secondary, collegiate and medical education, under improved modern schedules, in a dozen years, or less. But their calculations leave the question of the “wherewithal” entirely out of consideration. If properly counted in, it would add another dozen years to the number. It has been urged that these impecunious young men should be dissuaded from entering upon a medical course; but experience shows that they do not always prove to be the least useful and successful physicians by any means.

If the requirement of a collegiate literary course is to be exacted in the case of these young men, it shortens their medical career from twenty-eight years to twenty, or perhaps eighteen. And if the reduction of aggregate life-work were equally great in all cases, the medical colleges would be under the necessity of graduating annually, not forty-seven hundred physicians, but seven thousand. How perfectly dreadful!

Now, let us inquire what sort of an individual is this "average medical student"—this not very hypothetical personage about whom we have been speaking. He has been educated in the common elementary school, has acquired a fair knowledge of English, except that he is by no means an expert in the use of it; has become somewhat proficient in arithmetic, in geography and American history, and possibly has obtained some small measure of familiarity with one or two other subjects for which he happens to entertain a liking. Not a high degree of scholarship, we must confess. His age, at the time he conceives his tender passion for medicine, is anywhere from fourteen years upward. We must do him the justice to say that he is not indisposed to habits of reading, or even of study. If, now, he falls under the influence of a broad-minded physician, who wishes to encourage him in his desire for a medical career, he begins the study of Latin, physics and higher mathematics. Unfortunately, in nine instances in ten he is put to reading anatomy and physiology—not quite the worst thing that could happen to him—he might have been provided with a work on practice or *materia medica* instead. Thus equipped, he knocks, sooner or later, at the door of a medical school. If he should bring with him a young man who has enjoyed the additional advantage of one or two years in an ordinary—a very ordinary—high school or academy, the two will represent two-thirds, yes, three-fourths, of all the students in American medical colleges to-day. Further, it can with absolute truth be said that while there are scholarly students—quite a good many of them—in our colleges, those who have had a preparatory education carefully and intelligently adapted to secure them the highest possible aid in a course of medical study do not constitute two per cent.

A *résumé* of the preparatory educational needs of the medical student must include these elements: He should possess the



ability to speak and write the English language correctly and be able to express his thoughts with it freely, clearly and accurately, if not with elegance. He should have sufficient acquaintance with Latin to enable him to construct and interpret its terms and formulæ, and an elementary acquaintance with Greek will not come amiss. German and French may be valuable to the physician in his practice, but the American student in college has little use for them. Of history, he requires those portions which are related to the progress of medical art and sciences in various countries during the last twenty-five hundred years. For our own American history—let us say it with fear and trembling, knowing the temper of the American critic—he has no very important concern. The same statement may be made, and with even more emphasis, respecting political and statistical geography. In mathematics he must possess a knowledge of all the general rules and principles of arithmetic, with facility in the solution of all its more general problems. In his studies of anatomy, physiology, obstetrics and ophthalmology he will need to know the terms and many of the rules of mensuration, while for trigonometry and geometry he will have but little use, and for algebra none whatever. He should be a better penman than most of his predecessors, and strongly needs some skill in free-hand drawing. And then, the medical student urgently needs familiarity with those portions of logic which treat of observation and experimentation, and of the inductive process as it refers to scientific research.

Which of the natural sciences should be included? In a word, all. Medicine already lays most of them under contribution, and declares her purpose to lay hands on all the others whenever the occasion may arise. These sciences are sometimes characterized as forming a "circle." Rather it should be said they constitute a column, with physics at its base and psychology for its capital. Each of its parts bears important constructive relations to the others, and every one is a necessity to its perfect symmetry and strength. Physics, in all its departments, forms the foundation, and other foundation can no man lay if he would be a scientist in more than the name. On this basis rest astronomy, geology, physical geography and meteorology as so many illustrations and applications of funda-

mental physics. Above these are chemistry and mineralogy, completing the group of inorganic studies; and next in order we build the beginning of the organic—organic chemistry, general biology, botany, zoology and comparative anatomy. It is upon this rock that the first stones in a medical education should be superimposed—human anatomy and physiology, to be followed by pathology, hygiene and therapeutics. The student, whether in the medical college or in the public school, who undertakes the study of physiology before obtaining a knowledge of physics, is beginning his ascent of learning's ladder not at the bottom, but half-way up.

The medical student's preparatory training should include these two things: a knowledge of the sciences and a knowledge of science. He should be familiar with the methods and measures employed in the researches of science as distinguished from those of other lines of investigation; and before he enters a medical school he should have sworn fealty to science as his life-long mistress and queen. He should ever be conscious of the presence of the injunction, paraphrased from Solomon: "Science—not letters—is the principal thing; therefore study science."

The complete education of the physician is threefold: literary and philosophical, scientific, manual and mechanical. Heretofore the literary department of his preliminary education has constituted the lion's share, except that within quite recent years the necessity for the study of the natural sciences has been conceded, and general physics, general chemistry, and in some of our secondary schools biology, have been added to the curricula, and the subsequent study of medicine has been thereby greatly aided. Even yet, however, it must be said that, following the regular grammar-school period, a four-years' course in the ordinary high school or academy still leaves the student far below that proficiency in science essential to the best and most rapid advancement in a subsequent course in medicine. The lamentable fact that scientific education has been forced into a wofully subordinate position in the secondary schools of the United States has been fully admitted. In the report of President Eliot, of Harvard, and his famous Committee of Ten, with their nine Conferences, we are informed—though we well knew it before—that "as to botany,

zoology, chemistry and physics, the minds of pupils entering the high schools are ordinarily blank. When college professors endeavor to teach chemistry, physics, botany, zoology, meteorology or geology to persons of eighteen or twenty years of age, they discover that in most instances new habits of observing, reflecting and recording have to be painfully acquired by the students—habits which they should have acquired in early childhood.” And then, after bringing this accusation against our elementary schools, the Committee proceeds to establish a similar charge against our high schools and secondary institutions generally. Speaking of the reports from the Conference on Physics, Astronomy and Chemistry, the Conference on Natural History, which included biology, botany, zoology and physiology, and the Conference on Geography, which included physical geography, geology and meteorology, the Report uses this significant language: “The experts who met to confer together concerning the teaching of these subjects . . . ardently desired to have their respective subjects made equal to Latin, Greek and Mathematics in weight and influence in the schools; but they knew that educational tradition was adverse to this desire, and that many teachers and directors of education felt no confidence in these subjects as disciplinary material.” What! A system of studies requiring the most minute, accurate and comprehensive observation, the most ingenious experimentation, the most careful comparison and classification, the most critical and comprehensive analysis, the most profound and inquisitorial scrutiny of causal relations, and all this guided by the fixed rules and principles of logic and applicable to all the material events and phenomena of every minute of our existence. What! we ask: is this the part of our education in which “many teachers and directors of education have no confidence as disciplinary material” in the development of intellectual breadth and energy? Well! it would be interesting to know just why.

While we are considering the work of that celebrated educational Committee of Ten, there is one other point to be mentioned. We are led to infer that not all, but only “many” teachers lack confidence in the disciplinary value of a scientific education. Perhaps it may be allowed, nevertheless, that pupils contemplating a scientific vocation may have special



provision for such training as is essential to their proficiency therein. But on referring to the Report, we learn that one of the questions submitted to the nine Conferences was: "Should the subject (considered by each Conference respectively) be treated differently for pupils who are going to college, for those who are going to a scientific school, and for those who, presumably, are going to neither?" On this the Report says: "The question is answered unanimously in the negative by the Conferences. The Committee of Ten unanimously agree with the Conferences. Ninety-eight teachers, intimately concerned either with the actual work of the secondary schools, or with the results of that work as they appear in students who come to college, unanimously declare that every subject which is taught at all in a secondary school should be taught in the same way and to the same extent to every pupil so long as he pursues it, no matter what the probable destination of the pupil may be, or at what point his education is to cease."

If the Report of President Eliot's Committee of Ten means exactly what it seems to say in condemnation of elective courses of study in American secondary schools, and in favor of the continued subordination of scientific subjects of study in these institutions, the outlook for better preparatory education for medical students is anything but hopeful. I earnestly commend the facts presented in this paper to the consideration of the Conference when it shall take up the paper of Professor Allen on "Preparatory Studies and the Establishment of Preparatory Departments in Medical Colleges."

---

AN ADDRESS DELIVERED AT THE JUBILEE COMMENCEMENT OF THE  
HAHNEMANN MEDICAL COLLEGE OF PHILADELPHIA, ACADEMY OF  
MUSIC, MAY 12, 1898.

BY WM. TOD HELMUTH, M.D., LL.D., NEW YORK CITY.

*Mr. President and Alumni, Ladies and Gentlemen:*

When the committee appointed to arrange these interesting ceremonies, through its Chairman, Dr. Pemberton Dudley, requested me to assist in the semi-centennial celebration of the

foundation of my Alma Mater, though I felt much honored by the compliment, I accepted the responsibility with diffidence. First, on account of the proverbially critical nature of a Philadelphia audience, and second, because I was only definitely acquainted with the workings of the College during the earlier days of its existence—my removal from Philadelphia precluding an intimate knowledge of its more recent affairs. Therefore, if the few imperfect reminiscences of the old College partake rather of the ancient and uninteresting, and the names that may by chance be mentioned be unfamiliar, let me be excused on the plea that the items and personalities herein alluded to are matters of history that should be recorded for the benefit of future sons of my Alma Mater, and it gives me pleasure to know that I have been selected to so write—(*Litera scripta manet*) and to speak on this occasion in the city of my birth, of my education and of my early professional life.

In the production of life's pleasures and pains, three great factors stand conspicuously prominent. They are: Anticipation, realization and retrospection. Perhaps of the three, the last is the most stable, because anticipation is so often disappointed in realization. Of retrospection we are sure. The subjects it considers are facts that have happened or sentiments that have been experienced, and though time may have smoothed the roughness of the sorrow and mellowed the acuteness of the delight, still they remain within the call of memory, as integral portions of our past happiness or misery in our life's journey. Again, realization often records as calamities what retrospection—as the years roll on—proves to have been blessings in disguise. It is the latter of these qualities, reflecting over a pleasant pathway, winding in and out through the mazes of half a century, that I take into my confidence to-day, and as it turns the search-light of memory to stream over those early days of this Institution which correspond nearly with the beginning of student life—forgotten faces, forgotten incidents, forgotten pleasures, and perhaps a few forgotten pains, take shape and become distinctly silhouetted on the background of the past. As they, ghost-like, intertwine themselves into my thoughts, I am reminded of the gentle Elia who, in "Oxford in the Vacation" and "Christ Church Hospital Five and Thirty Years Ago," depicts his feelings of pleasure and profit

in the contemplation of his school-boy days, touched with a certain degree of sadness and regret which are conspicuous in most of his retrospections. You may also remember how humorous Hood who, in recalling the days passed in the old Academy of Clapham, although he ruefully exclaims,

“There was I birched,”

says afterward, in his more circumspect age, comparing the present with the past :

“Our topmost joys fall dull and dead,  
Like balls with no rebound,  
And often with a faded eye,  
We look behind and send a sigh  
Toward that merry ground.”

Why may not an humble doctor declare, as he looks backward over his student days, spent here in this city of his birth and education :

Here, where my Alma Mater proudly rears  
Her noble head, the pride of fifty years  
In glory sitting on her radiant brow,  
I stand to offer willing homage now.  
First of her race who fearless dared proclaim,  
*Similia* in the master's mighty name ;  
First of the schools. who to the startled world  
The banner of our simple truth unfurled.  
I love her yet, and may affection grow  
That budded here near fifty years ago.

*Ladies and Gentlemen :* The exercises of to-day, in addition to celebrating the usual Annual Commencement of this College, close a most successful and instructive jubilee, commemorating, as you are aware, the semi-centennial anniversary of its foundation. Strictly speaking, however, the Hahnemann Medical College was not incorporated until 1867, and after two courses of lectures, viz., in 1869, it united with the Homœopathic Medical College of Pennsylvania, which had then been in successful operation for twenty-one years. Practically the latter was the first Homœopathic Medical College in the world wherein all the branches of medical education were taught in the English language, and where not only the degree of *Doctor Medicinæ* was conferred, but the additional title legally given and distinctly expressed in the text of the diploma *Doctor Medicinæ*



*Homœopathicæ.* It must not, however, be forgotten that on the 10th of April (Hahnemann's birthday), 1835, there was founded in Allentown, Pa., an institution known as "The North American Academy of the Homœopathic Healing Art." In 1836 its doors were opened for the reception of students with a course of ten months, viz., from November 1st to August 31st; during which period two months were especially devoted to instruction in Homœopathy, viz., from June 15th to July 15th and from December 15th to January 15th. In those times almost all the men who embraced the system of Hahnemann were already graduates in medicine, and were anxious for instruction in Homœopathy, its materia medica and therapeutics, and cared little for the collateral sciences with which they were already familiar. It is not, therefore, surprising that this college did not long survive, especially as all instruction was given in the German language, which fact alone, as it was established among our English-speaking people, necessarily would debar it from obtaining a large class of students. There were but one or two courses of lectures delivered in this institution, and the building was shortly after sold for debt. The small pamphlet which I hold in my hand is a memento of the Allentown Academy; it is its constitution and by-laws, published in Philadelphia in 1835, nearly sixty-three years ago. (See opposite page.)

I am an Alumnus, with several others (alas! not many) on this platform, of the Homœopathic College of Penna. I was matriculated in the year 1850, and graduated in 1853, and was elected to the Professorship of Anatomy in 1856. My uncle, the late William S. Helmuth, was the Professor of Theory and Practice during my studentship. I had removed from Philadelphia when the colleges became united, and knew nothing of the circumstances, excepting that the competition that always arises when two medical colleges are situated in the same city or town resulted, and it was thought advisable, as "in union there is strength," to amalgamate the two institutions; necessarily, therefore, all my memories cluster round the old college in Filbert Street. Ah! how well I remember it—with its winding stairs on each side of the hall, presided over by an old janitor who majestically handled a bell of most discordant clang at the beginning and end of each hour. Glad were we to hear it at the end of the sixty minutes—it meant temporary

## Verfassungs-Urkunde

der

## Nordamerikanischen Akademie

der

## homöopathischen Heilkunst.

---

Gegründet am 10. April,  
eröffnet zu Allentown den 27. Mai 1835.

---

---

---

Philadelphia:

Gedruckt bei J. G. Wesselhoeft, No. 9, Broad St.

1835.

freedom—hateful was its sound to us at the beginning, it meant another “grind.” I may mention, however, *en passant*, that this consequential old and rotund janitor, who had his den under the staircase in the hall to the right side of the entrance, from which he viewed the incomings and outgoings of the students from a glass-door in his cubby-hole—could “write himself M.D.” His name was Martin Derr. He never smiled save at the end of the term, when in exchange for a five-dollar gold piece he handed to each graduate a round, oblong, green, japanned tin box, containing the long-coveted parchment. I have my own now, dented, and scratched, and worn—but to be transferred to my children when the proper time shall come. I can see distinctly, even at this moment, the lower lecture-room, and Prof. Semple standing forth with his long

hair behind his ears, demonstrating the production of hydrogen in a simple way from a pneumatic trough made out of an ordinary washing-tub and retorts constituted of pipe-stems and old bottles. The hobby of Dr. Semple was that an experienced chemist needed little apparatus that he could not prepare for himself with the exercise of a modicum of ingenuity and mechanical skill. But chemistry has become a vast and comprehensive science since then.

In the same room Prof. Small—whose name belied him both from a mental and physical point of view, for he was great both as to his corporeal and mental attributes—poured out his ponderous words on physiology, especially that of sleep, until their weight of wisdom o'erpowered the sensibilities of his hearers. Often the subject of his lecture was practically demonstrated before him by the somnolence of his class. There also my revered uncle and preceptor, a second father to me, a conscientious student of Homœopathy and a painstaking physician, lectured upon the institutes and practice of medicine—orthodox, rhetorical, precise and scientific were his words; good, oh! how good, but dry as the sands of the Desert of Sahara. I may recite here a truth, never vouchsafed the public before, and that is I never paid any great degree of attention to these lectures, because I lived with my respected relative during those years of student life. I knew just in what desk the lectures were kept, and where the prepared questions, accurately numbered for the coming quiz, could be found—who can blame me?—think of it, forty-eight years ago!

Passing up the winding stair to the second floor the museum was reached. It occupied the whole area of the building, and was really a fine, spacious apartment. Even in those days it possessed the nucleus of its present excellent collection of specimens, which had been purchased from the late Dr. Paul B. Goddard, Professor of Anatomy and Surgery in the old Pennsylvania College, by Prof. Francis Sims, our then Professor of Surgery. They stand to-day in the museum. Chief among them are the beautiful and complete wax preparations of diseases of the eye, and many well-colored plates of fractures and dislocations.

Over the museum was the little amphitheatre with a professor's room on the left and a private dissecting-room on the right, wherein I have spent many happy hours preparing ana-



tomical lectures. There, in the semicircle, I have heard dear old Matthews, blown and breathless from the ascent of the long and winding stairs, exhibiting too plainly the ravages of that incurable disease which was soon to close the scene of his labors on earth, seated in a chair (he was too weak to stand) and unfolding to us *Materia Medica* with an energy and enthusiasm that exhausted him. There also did Walter Williamson, in the earnestness of perfect faith and with the courage of his convictions, interweave the knowledge of the law of cure into all his teachings of obstetrics. There also from Gardiner I received the anatomical knowledge that rendered me fitted in two years afterwards to stand in his place in that self-same lecture-room, and to endeavor to emulate the lucidity of his teachings. It was in that same amphitheatre that

“I crammed for each quiz, applauded with my feet,  
And cut my name upon my chosen seat,  
The right-hand corner of the second row;  
I cut it there near fifty years ago.”

Oh! how much we thought we knew in those old days! Never have I since had such an overwhelming sense of my unerring judgment, wisdom and knowledge, as I sat in the Filbert Street lecture-room, and criticized the teachings of those men whose acquirements rendered them as modest as my ignorance and inexperience proclaimed me both conceited and impertinent. I think most medical students are affected in this manner—why, I cannot tell. I remember once when that revered pioneer of Homœopathy, James Kitchen, a clear-headed thinker, and among the first in Philadelphia to embrace Homœopathy, stated in a clinical lecture that in a case of unlimited green apples in the stomach of a young robber of orchards he had ventured to suggest that perhaps a good old-fashioned dose of castor-oil might prove efficacious, the whole class of inexperienced youngsters rose in rebellion because he had dared to express a sentiment so disastrous to the progress of Homœopathy. Think of a dose of old-fashioned castor-oil administered with such good intent impeding the progress of a great scientific truth! As a matter of history I would like to read to you the advertisement of the first course of lectures of the old college. It is one of my most precious mementos. It is taken from the

*American Journal of Homœopathy*, edited by Dr. S. R. Kirby, and published in New York in 1848.

# HOMŒOPATHIC MEDICAL COLLEGE OF PENNSYLVANIA.

*College Building located in the rear of  
229 Arch street, Philadelphia.*

Preliminary Instructions will commence on Monday the sixteenth day of October. The regular course will begin on Monday, the sixth day of November, and continue until the first of March ensuing.

Jacob Jeanes, M. D., Professor of the Principles and practice of Medicine.

Caleb B. Matthews, M. D., Professor of Materia Medica.

Walter Williamson, M. D., Professor of Midwifery and the Diseases of Women and Children.

Francis Sims, M. D., Professor of Surgery.

Samuel Freedley, M. D., Professor of Botany.

Matthew Semple, M. D., Professor of Chemistry.

William A. Gardiner, M. D., Professor of Anatomy.

The Chairs of Physiology and Pathology remain to be filled.

Clinical instruction in Medicine and Surgery will be given at the College.

Lectures will be delivered throughout the year, but the winter course only will be obligatory—attendance on the summer course being at the option of the student.

Standard works on Homœopathy and such books as are generally used in other Medical Schools can be used as text books.

Students who have attended a full course of Lectures in another Medical School, can, after attending the winter course of this college, graduate next Spring, if their attainments justify it.

Fee for a full course	\$100.00
Practical Anatomy	10 00
Graduation Fee	30.00

W. WILLIAMSON, M. D.,

*Dean of the Faculty.*

No. 80, North Eleventh-st., Philadelphia.

This was the public announcement of a great fact, viz., that Homœopathy was to be taught in a legally chartered and fully equipped institution, to all those who desired a medical education. No one at that time could imagine the immense significance of such an announcement. It marked an era from which in all time to come the progress of our school, as a school of medicine, would be dated. The statement is verified to-day in the computation and celebration of our first half a century. My friends, there are epochs in the annals of science as well as eras in the history of nations of which the world takes note. Old Father Time regards them as his landmarks, and chronology respects them in her computations; they mark the mighty events which have transpired in the history of the past, and serve as monuments on which to rear deductions for the future. The foundation of the first college to teach Homœopathy *was* an epoch in the progress of its science. It *was* a focus from which has radiated streams of knowledge in every direction. When the position of Homœopathy in those days is considered and a comparison is made with its present status, I can boldly say that no new science ever introduced, no innovation in medicine ever announced, no system of therapeutics ever inaugurated since the time of the 80th Olympiad has spread with such amazing rapidity and settled itself so permanently among the intelligent and educated portions of the community as Homœopathy. The opposition that it encountered, the ostracism it received, the ridicule that was showered upon it, the persecution its early upholders were called upon to evidence, the fanaticism, bigotry and intolerance of the old school in those times are matters of history, and need not be repeated here. I was only cognizant of the latter portion of this fierce and demoralizing ebullition of sentiment; but even then I can recall friendships estranged, social relations sundered, kinship ignored, expulsion from societies and ejection from hospitals frequent—so deep was the feeling of the dominant school toward those who believed they saw in the law of *Similia Similibus Curantur* a better, safer, and more reliable method of curing the sick. To-day there are in the United States

9 National Homœopathic Medical Societies.

2 Sectional Homœopathic Medical Societies.

33 State Homœopathic Medical Societies.



- 85 Local Homœopathic Medical Societies.
- 39 Homœopathic Medical Clubs.
- 66 General Homœopathic Hospitals.
- 74 Special Homœopathic Hospitals.
- 57 Homœopathic Dispensaries.
- 20 Homœopathic Medical Colleges.
- 31 Homœopathic Medical Journals.

These statistics are perfectly authentic, have been prepared with great care, and are taken from the Report (1897) of the Committee of Organization, Registration and Statistics, presented to the American Institute of Homœopathy at its last meeting.

It would seem especially appropriate in this connection and upon this Commencement Day which celebrates the first half-century of the existence of the College, that allusion should be made to its first public Commencement, which took place in this city at the Musical Fund Hall, on March 15, 1849.

The notice on opposite page from *The Philadelphia Inquirer* for March 16, 1849, gives a detailed account of the function.

I can show to the audience, also, as matters of antiquarian interest, the tickets for many other commencements, which I have carefully preserved and which appear to possess a peculiar significance on this our Fiftieth Anniversary. Little did your speaker conceive, when he preserved these mementos of his college life, that they would be produced on such an occasion and with such surroundings. As I look at these faded and time-discolored bits of parchment, each one turns a page in the volume of the past, and by their mnemonic influence incidents of time and place, faces that had faded from memory, environments that had been entirely forgotten, rise before me with such sharpness of outline that I can scarcely believe they belong to the days that are gone, but have only been hidden by the daily and hourly duties and responsibilities of an arduous professional life. Here, for instance, are two of these tickets, one yellow and one white; both were issued for the same Commencement Day, viz., February 27, 1857. The yellow one was devised by one member of the Faculty, the white one by another respectable member of the same body. Those two tickets were the cause of such a hot contention at a certain Faculty meeting that an estrangement existed between the parties for

**Commencement of the Homœopathic Medical College.**—The first public Commencement of the Homœopathic Medical College of Pennsylvania, took place on Saturday, at the Musical Fund Hall, in presence of an audience, the brilliancy of which was the subject of conversation by all present. The weather could hardly have been more favorable, and no Medical Commencement in Philadelphia was ever more honored. Such a captivating array of beauty and fashion, has seldom been looked upon. The orchestra was filled with Johnson's celebrated colored band, numbering some of its best players of brass and string instruments, and these favorite musicians fairly excelled excellence itself in the execution of the delicious airs they selected for this occasion.

The following was the programme of exercises:

Music.

Prayer by the Rev. Mr. Burrows.

Music.

Valedictory Address, by Professor Helmuth.

Music.

Address and Conferring of Degrees, by the President, Hon. A. V. Parsons.

Music.

Benediction.

Music.

There were two novelties in the exercises. The valedictory was pronounced previously to the ceremony of conferring degrees, and the degrees were given in English, instead of Latin, as is customary with other colleges. Judge Parsons, the President, prefaced this ceremony with a few appropriate remarks. The Valedictory of Professor Helmuth was an able and scientific exposition of the principles of the system of Homœopathy, and he was listened to by the large, intelligent and refined auditory, that heard him, with deep and flattering attention. The subjoined are a list of the names and places of residence of the young gentlemen who received the Diploma of the College—Ebenezer H. Bacon, Maine; George W. Bigler, Maryland; George W. Chittenden, Wisconsin; John Redman Cox, Jr., Philadelphia; Lewis Dodge, Michigan; James H. E. Frost, Maine; Richard Gardiner, Philadelphia; James E. Gross, Maine; Washington Koppin, Rhode Island; Frederick Humphreys, N. York; Daniel Janney, Virginia; Ezra Leonard, N. York; Joseph G. Loomis, New York; D. R. Luyties, Philadelphia; Barton Munsey, North Carolina; Thomas A. Pierce, Maine; Jacob Frederick Sheek, Philadelphia; Jonas Y. Shultz, Penn.; Theodore S. Williams, Penn.; Augustus S. Wright, Ohio. Total, 20.

The numerous and select audience in attendance at this Commencement, will afford an idea of the great interest that is now felt in our city in the new practice of medicine. The success of this college has been unprecedented. The institution—the first of the kind that has been established in Philadelphia—is scarcely two years old. At its first session it had only fourteen matriculants, and at its first Commencement, which was of rather a private character, graduated but seven doctors. At its session, just closed, it had fifty-five matriculants, and has graduated, as will be seen by the list above, twenty students. The college building is located in Filbert street above Eleventh—the edifice formerly occupied by the Pennsylvania Medical College.

some time thereafter. I would now recall an incident that took place at one of the final examinations in the early days of my Alma Mater, and finally say a few words to these fortunate young doctors who to-day commence their professional careers, premising that, after an experience of forty-two years in the amphitheatre, I may lay claim to the proper understanding of the tastes, the sentiments and the aspirations of applicants for the doctorate. My whole life has been interwoven with that of medical students, my hair has turned white in their service, the wrinkles have come upon my forehead, the crows' feet have gathered about my eyes; the spectacles have become an integral part of the man; temper begins to wane, and muscularity abates; but I find no diminution in my attachment to the medical student, and, what is more, I think my classes know it. Therefore, I feel I have acquired the right to address a few words in conclusion to these young men. I have taken the liberty to put them into verse:

Once in the springtide of a year long pass'd  
 A student sat, wrapt in profound surmise;  
 Now that the Ides of March had dawn'd at last,  
 Would he be call'd for honors or a prize?

For three long terms this Æsculapian son  
 Had deeply dived in Hippocratic soil,  
 Had "rushed" the Freshmen and the battles won,  
 And lavishly had burned the midnight oil.

This was his last "exam"—the hour had come.  
 Now for the bright-eyed girl he held so dear,  
 Now for the love of those old folks at home,  
 Now must his memory shine bright and clear.

The "oral" was the method in those days;  
 "Cribbing," that wretched subterfuge, unknown;  
 A manly student, howe'er wild his ways,  
 Should scorn to stand by knowledge not his own.

But desultory dreaming soon did pass,  
 When, ever eager for the student's weal,  
 The old professor, idol of the class,  
 Thus introduced Anatomy's ordeal:

"On the fourth ventricle's anterior wall  
 A groove is found; now give its name to me."  
 The youth flushed bright; he knew—he could not fall.  
 "The *Calamus scriptorius*," said he.



"Describe the pharynx," said this quiet man ;  
 "Then give to me its muscles, and detail  
 The number of its op'nings—if you can.  
 Remember, boy, there s no such word as fail."

"The pharynx," said the youth, his own so full  
 That scarce a syllable would deign to flow,  
 "Extends by its constrictors from the skull,  
 And touches the œsophagus below.

"Its openings are seven—two are wide.  
 Mouth, nares and œsophagus make four.  
 A Tube Eustachian on either side,  
 One for the larynx, and there are no more."

The questioner arose ; his hand he laid  
 Upon the shoulder of the trembling youth ;  
 "Well done, my boy," with gentleness he said,  
 "All creeds may fail, Anatomy is truth."

And that dear man, a learned professor then,  
 Long since has pass'd to his eternal joy.  
*Facile princeps* 'mong his fellow men,  
 And I—well, yes—I was that beardless boy.

Ah ! why do these old scenes arise again  
 Out of the past and colors fair display ?  
 By what peculiar fantasy of brain  
 Do college days return to me to-day ?

Sometimes a strain of music can exhume  
 Sweet reminiscences of days long fled ;  
 The faintest breath of flowerets in bloom  
 Can bring to life the faces of the dead.

So, when Commencement time again rolls round,  
 And "crams" and "quizzes" fill collegiate air,  
 When students *always* in their seats are found,  
 And "rushes," "choruses" and "yells" grow rare,

The very atmosphere that time recalls,  
 When all my life was *forward* to my gaze ;  
 Then do I start—the present so appalls,  
 For *backward* now I only look through haze.

Then list to one now far upon his way  
 Along the lines in which his life was cast ;  
 This is the lesson that he would convey,  
 That *work in youth brings harvest at the last.*

Now is the time, while youth and strength abide ;  
 Now, while the current of your blood runs free,  
 Now, when the world stands open to you wide,  
 Join hands to battle for humanity.

Now is the time to face your secret foe,  
 Now, when your self-reliance rises high,  
 Now is the time to vanquish as you go,  
 Now is the time to conquer or to die.

No memory freighted with the lapse of years,  
 No sweet memento graven on the brain,  
 No heart's remorse all sodden with your tears,  
 Can call these youthful days to life again.

So buckle on your armor for the fight,  
 With knowledge rivet it at every pore ;  
 The pestilence that walketh in the night  
 May spring upon you ere the day is o'er.

Disease and death are lurking by the way,  
 In secret ambush dire contagion lies ;  
 Up, men ! and smite them while ye may,  
 With valor that e'en destiny defies.

Then, when the time shall come to lay you down  
 The battered armor which your fame has won,  
 And silver hair shall deck you with its crown,  
 While Conscience whispers in your ear " Well done !"

Hark to the strain that steals upon your ear !  
 What tune is that resounding far away ?  
 What is that melody so sweet and clear?—  
 " *The band is playing on Commencement Day.*"

### SUSPENSION IN LOCOMOTOR ATAXIA.

BY JOHN J. TULLER, M.D., PHILADELPHIA.

It seems strange that some of the best-known forms of treatment of diseased conditions have been discovered, tried, then, from lack of knowledge of their indications, found apparently wanting and thrust into oblivion. Resting in this state for a longer or shorter period, some one of a firm, investigating mind searches them out, exposes them to the light once more, giving the indications and the contraindications for their use, and they become fixtures in our system of therapeutics.

It was Professor Charcot, of Paris, who introduced the system of treatment by suspension in cases of locomotor ataxia, in the Hospital Salpêtrière, in 1888. His success with it was remarkable; and while it was afterwards tried in England and Ger-

many with much less favorable results, the fact still remains that it is one of the most important, if not the most important, form of treatment for tabes dorsalis in France to-day. In the Salpêtrière alone one can see from twenty to thirty patients a day undergoing this treatment, and with very favorable results. After visiting Paris and watching this treatment as it is applied there from day to day, one would naturally be impressed with the belief that in Germany and England it had been used without a thorough understanding of the indications and contraindications, and had therefore been discarded, having produced unfavorable results.

But let me consider some of the cases treated by Professor Charcot and the results obtained. In his clinics given in the Salpêtrière, Professor Charcot, in the year 1889, exhibited the following cases, and demonstrated the virtue of this form of treatment upon these cases.\*

*First Patient.*—M. CHARCOT: Here is first a strong, vigorous man, 51 years of age, named D., who is in a business the functions of which require that he stand or walk the entire day. He has been markedly hindered in his work during the last two years, the period at which the motor inco-ordination of his lower extremities began to trouble him.

Briefly, our observation shows the state of the patient at the time of his first suspension to have been as follows: The onset of the disease, five years ago, was by the crisis of excessive lightning pains. Two years ago occurred a spontaneous fracture of the right fibula. After that time the gait became very difficult, the motor inco-ordination very pronounced. The patient could not walk long; he was obliged to sit down at every instant; very frequently, while walking or standing, his limbs suddenly gave way under him; the lightning pains became almost continual; they frequently prevented sleep; urination difficult, requiring five or six attempts to empty the bladder; the sign of Romberg was markedly pronounced; for a year past complete impotence; absence of the patella tendon reflex.

The first suspension took place the 22d of October, 1888. The number of suspensions up to date have been thirty-three, each lasting from one to three minutes. In the note relative

---

\* Translated from *Leçons de Mardi*, 1889.



to the effects produced we find the following: From the second suspension a positive amelioration has been manifested in the gait and in the micturition. During the following month the lightning pains did not return. They have returned since that time occasionally, but were much less intense.

Twelfth suspension: The micturition is again ameliorated. The patient has been able to get off the street-car alone, even while in motion, which he has not been able to do for over two years.

Fifteenth suspension: The sign of Romberg has disappeared; the weakness of the lower limbs has not existed for some time.

Twenty-third suspension: The patient has had an erection for the first time in a year; the knee-jerk continues absent. The patient says he has not felt the pains except when the weather was very damp.

M. CHARCOT (to patient): The pains that you suffered, were they very intense? How long have you had them?

PATIENT: They were very acute; they were like the stroke of a poniard; latterly I had them almost constantly, or at least every two or three days; they were almost unbearable; frequently it was impossible to sleep.

M. CHARCOT: Will you tell me what has occurred in regard to the pains since you have followed the treatment?

PATIENT: The pains disappeared after three or four suspensions. They have returned since, but not as severe, and after more suspensions have disappeared again. They have returned again in the last three or four days, but have been very slight and of short duration.

M. CHARCOT: This is certainly an interesting result. Do not forget that when these pains are intense tabetics are apt to contract the vicious morphine habit. If one could stop or prevent this habit by the aid of repeated suspensions, this alone would be a great benefit.

TO THE PATIENT: How was the fracture of your leg produced which is noted in your case?

PATIENT: I was seated before a desk, and I stooped down to caress my dog, which was at my feet. The fracture occurred, I don't know how; I did not fall; I did not make even a false movement.

M. CHARCOT: This is truly a tabetic fracture.

TO THE PATIENT: Tell me of your gait; what is the result in this regard?

THE PATIENT: I walk decidedly better; I stand better; before, I was afraid of falling every instant, because my limbs became suddenly weak; this is gone; I can walk almost all day in the store without being forced to sit down at every step.

M. Charcot asked the patient to stand erect, the feet together and the eyes closed. (The swaying of the body, with the tendency to fall in this position, is the symptom searched for.) One learns from this the absence of "the sign of Romberg." Then, the patient being seated, the knees crossed, a gentle stroke upon the patella tendon shows the absence of the knee-jerk.

TO THE PATIENT: Will you tell me if you have improved in the emission of the urine?

PATIENT: Oh! in this the amelioration is very marked also. Formerly I was compelled to make five or six attempts; now I urinate easily all at one attempt. It is the same as before I was sick.

M. CHARCOT: There is another result obtained of which he has not spoken, without doubt, from timidity, but which we cannot pass in silence; that is, the erection and sexual desire have reappeared for several weeks. The sexual relations have been quite normal, except, he tells us, that the sensations have not been quite the same as formerly. *En vor résumé*, gentlemen, you see the amelioration in the symptoms is pronounced in every line; and one would know but little of the subject, I think, to assume here, more than in the cases that follow—to render an explanation of the effects produced—an influence of "suggestion" because the improvements are manifested slowly, progressively, successively, during a period of three months, and they are not proved to the contrary since the first.

*Second Patient.*—M. CHARCOT: The second patient is one named D., 43 years of age. He occupies the position of inspector on a board of commissioners. Nervous heredity very pronounced; father excitable, a teacher, actively occupied in politics; mother quick-tempered and hasty; a brother a suicide; syphilis at the age of twenty years.

The fulgurant pains commenced five years ago; the tabetic

gait dates back a year; knee-jerks absent; sign of Romberg; Argyll-Robertson pupil; micturition difficult; impotent since the commencement of the year 1888. Commencement of treatment October 22, 1888. He has had, up to date, thirty-six suspensions of from one-half to three minutes' duration.

From the second suspension there was diminution of the sensation of weight which existed in the lower limbs; the gait appeared to be a little easier. After the eighth suspension, very marked amelioration in the gait, which became less affected by darkness; the patient could go down stairs more easily; the micturition less slow. After the twentieth suspension, great progress in the gait; the patient could take long walks; for instance, recently he walked from the Place d'Italie to Autreuil (a distance of several miles) without a cane; the fulgurant pains have become, after some oscillations, much more rare and very easily bearable; they do not hinder the sleep; the sign of Romberg has in great part disappeared, the knee-jerks being always absent.

M. CHARCOT (addressing the patient): All that I have said, is it exact?

PATIENT: Yes, sir, certainly. I have had no pain now for two months. Formerly I had them frequently, and very often I could not sleep; now I sleep well.

M. CHARCOT: When did you commence to walk better? How about the bladder's error?

PATIENT: Fifteen days after the commencement of the treatment I perceived that I could walk better. This was followed by amelioration from day to day. To-day, as you say, I can take long walks without a cane. I pass the water much better; almost as well as before my sickness. I have erections now, too, except that they do not serve me. Yesterday I stepped off the street-car while in motion.

M. CHARCOT (to patient): Don't perform too many of those feats; the bones of tabetics are very fragile; ask the patient who preceded you here about it.

*Third Patient.*—M. CHARCOT: He is named G.; aged 32 years. He was attacked by syphilis at the age of 15 years. Began two years ago with difficulty to walk; frequent giving way of the lower limbs; fulgurant pains began to disturb him a year ago; frequent desire to urinate, and, at times, inconti-



nence of urine; sensation of cotton in the feet and legs; knee-jerk absent; no sign of Romberg; erection rare and imperfect.

Began the treatment 12th November, 1888; has had twenty-four suspensions. A certain amelioration in the gait commenced after the fourth suspension; at the same time less frequency in the desire to urinate. After the seventh suspension the patient says he felt better; that the sensation of cotton in his feet was gone; that he walked better. After twenty suspensions the results acquired are as follows:

The patient can take long walks without the service of a cane; his legs do not give way under him; the sharp pains have disappeared; they are only represented by a simple tickling sensation, which incommodes but little; the numbness in the lower limbs has ceased; there is no more incontinence of urine; the erections are stronger and more durable.

M. CHARCOT (to patient): Will you tell us what you think of the effects of the treatment you have followed?

PATIENT: Monsieur, that which is plainest is that when I commenced the treatment I was obliged to come here with my wife, who supported me by one arm, while I supported myself on the other side with a cane. I came a good ways, because I live nearly three-quarters of an hour from here—Rue de la Tombe-Issoire, near the Park Montsouris. To-day I make the same route alone, without being supported and without cane. It is now a month that I have come alone.

M. CHARCOT: Tell us of your pain and the urine.

PATIENT: I have no more sensation of cotton in the feet; I have no more pain, but I feel sometimes yet a species of tickling which appears to replace the pain; I urinate almost the same as formerly.

*Fourth Patient.*—Extract from the observation: B. (Louis), age, 41 years; no syphilis. An uncle on father's side was attacked with progressive general paralysis. Onset in 1887 by impotence; complete absence of erections. Motor inco-ordination of the lower limbs was very marked. The lightning-like pains were not intense, but there was a painful sensation and a dulling of the sensibility of the soles of the feet. The knee-jerks were absent; sign of Romberg very pronounced; difficult urination; at times some incontinence; Argyll-Robertson pupil.

Commencement of treatment, October, 10, 1889. Thirty-eight suspensions, from one-half minute to three minutes each. The gait commenced to be more sure from the third suspension, the urination more easy, and from this time he ceased urinating in his trousers, as he had so frequently done before. After the fifth suspension the sensibility became normal in the soles of the feet. After the sixteenth suspension the micturition was normal. After the twentieth suspension was produced the first erection experienced for a long time. After the thirtieth suspension the results obtained are: a very satisfactory condition of the gait; the micturition is good and the pathological sensation does not exist in the feet; the sign of Romberg has disappeared or, at least, has become scarcely noticeable; the knee-jerks continue absent.

*Fifth Patient.*—Named S.; 52 years; syphilis seven years ago. Onset of tabes, only two years ago, by a sense of feebleness in the lower limbs and a pronounced rapidly-advancing difficulty in the gait; sign of Westphal, sign of Romberg, sign of Argyll-Robertson are present. The fulgurant pains were manifested, for the first time, only eighteen months ago. They are not intense, light incontinence of urine, slight anæsthesia of the soles of the feet, erection very feeble. Commencement of treatment November 14, 1888. After the fourth suspension a very marked amelioration in the gait. The patient could walk much longer than previously and with much less fatigue. After the sixth suspension the pains ceased to exist; less numbness of the soles of the feet; the sign of Romberg was less marked. After the twelfth suspension the micturition was notably ameliorated. About the twenty-second suspension the erections, to the great astonishment of the patient, reappeared more frequent and more perfect. The knee-reflexes remain absent.

It does not to me appear necessary, gentlemen, to enter into the details concerning the five other cases of locomotor ataxia which are, in general, described by the preceding, and in which the effects produced by suspension have been very nearly identical. But I desire to mention particularly that in four other cases, of the group of fourteen, though the ataxia was in general symptomatically the same as in the other ten, the results produced were almost or absolutely null. In one of these

cases they could be considered, perhaps, as having been rather unfavorable.

The case in question is one named G.; age, 32 years; nervous heredity; very excitable; syphilis. In this patient the evolution of the disease had been extremely rapid, because in the space of six months the most diverse symptoms of the tabetic series had reached their highest development. At the time when the treatment was commenced are noted the following: Ptosis and strabismus; nocturnal incontinence for three months; the gait very difficult, very inco-ordinated; sign of Romberg very accentuated; absence of the knee reflexes; anæsthesia of the soles of the feet. Commencement of the treatment, the 22d October. The number of suspensions thirty-one, of from one-half to three minutes each. During the first month results favorable. Thus, after the fourth suspension, the inco-ordination was distinctly less. About the twentieth, the micturition was ameliorated, the anæsthesia of the soles of the feet had disappeared, the sign of Romberg was less pronounced. But from the twentieth to the twenty-fifth suspension, without any reason to explain it, an aggravation marked by a return of the motor inco-ordination, an attack of the fulgurant pains more intense than ever, and a falling of the left upper eyelid. The treatment was suspended, at least for the time. Every medallist has his reverse; this is almost an axiom. The treatment by suspension cannot escape the rule.

*En résumé*, gentlemen, out of fourteen cases of locomotor ataxia treated by suspension, during a period of three months, we note, in ten cases, a very decided amelioration, and in many of them a very remarkable relief of most of the spinal symptoms. In four cases only the effects were null, or scarcely appreciable, and in one of them, after a period of relief, there was an aggravation of all the symptoms. In some cases there was a form of vertigo resulting from the wrong application—quickly corrected—of the chin-piece. In one case only, when the patient was attacked by the laryngeal crisis—this, however, was not one of the present group—the treatment was suspended after the first suspension, because of a sensation of strangling produced by the application of the head-piece.

We recall that all these patients were true tabetics, already advanced in the disease, and in which, in consequence, the



diagnosis had been clearly established. In almost all, the amelioration commenced from the first in the gait, in the inco-ordination. This was explained from the first suspension. The patients have told us often that directly after the first suspension the gait was easier, more certain. This amelioration at first lasted but two or three hours, but after a certain number of suspensions it became pronounced and permanent. The patients could stand erect much more easily; they could walk without assistance, without canes, take long walks, etc., etc. The disappearance of the sign of Romberg, when present, has been almost always a tardy phenomenon. In no case have we seen reappear the knee reflexes. The bladder troubles have been modified, fortunately, in most of the cases—it is true, often late. Micturition has been regulated; it has become much easier. The incontinence has disappeared, or at least has been considerably relieved. In some patients the bladder functions have become normal. In some cases, too, the impotence has disappeared, a manifestation so frequent in tabes, and one so troublesome to the patient.

The fulgurant pains must be cited among the symptoms, which have seemed to be most frequently benefited by the treatment by suspension; this result has often been obtained from the first suspension. It has been easy to appreciate in many cases where the pains become almost continuous and disturbed the sleep. We must not forget that many times the sensation of numbness of the feet was relieved or has disappeared, and that, in two patients, the plaques of anæsthesia of the soles of the feet have returned to normal. Finally, it seems to us that the general state has been the most often relieved and the sleep frequently improved, a circumstance that does not appear to me to owe its existence entirely to the disappearance of the fulgurant pains. After all the preceding, gentlemen, it will without doubt appear to you evident, as to me, that the treatment of progressive locomotor ataxia by suspension, such as has been employed by Dr. Motchoutkowsky, well deserves to be drawn out of the oblivion into which it has been plunged until now, and placed again in the light. The results obtained up to the present time are, to my mind, striking enough for it to be seriously recommended to the attention of physicians, particularly those devoted to the study of neuro

pathology; and, as far as I am concerned, I can testify that I have never observed, in ataxia, under the influence of the different other forms of treatment that are employed, the amelioration so pronounced, or produced so rapidly in so great a number of patients.

It was in 1882 that Dr. Motchoutkowsky, of Odessa, published the results of his experience with this form of treatment. The article was published in a Russian medical journal and was not brought into prominence until Professor Charcot introduced the treatment in the form used by Dr. Motchoutkowsky in the Salpêtrière. In a lecture describing this form of treatment he refers to a case occurring in the experience of Dr. Motchoutkowsky as an illustration of the benefits and the permanency of the benefits resulting from the treatment by suspension.

It is as follows:

A man; age, 49 years; no previous history of syphilis. The fulgurant pains were excruciating. The constant girdle pains were very severe. The motor inco-ordination was developed to a very high degree, and the sign of Romberg very pronounced. The knee reflexes were absent; there was a very marked diminution in the sensibility of the lower limbs. Difficult urination. Impossible to accomplish the sexual act. Myosis.

After twenty-nine suspensions the patient walked better; his gait, in reality, had returned to almost normal. It was no longer necessary to assist himself with a cane as he had previously done, and he could hold himself erect upon one foot for two minutes. The fulgurant pains had become much more rare and much less severe, at times being hardly perceptible. The treatment, after these encouraging results, was continued, and the number of suspensions in all was ninety-seven.

When the treatment was finished the results obtained were as follows: 1st. The fulgurant pains had completely ceased to exist. 2d. A very remarkable diminution in the motor inco-ordination while walking; the patient, without cane, could easily climb to the fourth story. 3d. The disturbances of the sensibility which existed in the lower limbs, and in particular the sensations of cold and tingling, which were very severe, disappeared completely, as also did the girdle pains; return of the normal sensibility. 4th. Disappearance of the sign of

Romberg. 5th. Light augmentation in the volume of the muscles of the lower limbs, which had commenced to atrophy.

The treatment had no effect upon the weight of the body, nor upon the condition of the knee reflexes, which remained absent. No modification in the myosis. A return of the sexual functions, which previously were completely abolished. In a letter which he was kind enough to address to me recently, Dr. Motchoutkowsky informed me that this patient, who has stopped all treatment for five years, actually fills the position of manager of a public carriage station at Odessa; he is obliged to walk from three to four miles daily. The fulgurant pains have never reappeared.

This demonstrates the experience of the physician whose system of suspension has been employed in France since Professor Charcot first introduced it in the Hospital Salpêtrière, in Paris, in the year 1888. In the following two months after the above clinic was given, one hundred and fourteen cases of locomotor ataxia presented themselves at the dispensary of this hospital. Time and space will not allow me to give the results of the treatment of all these cases in detail. In general dispensary work a large number of the patients are of the floating variety, passing from one dispensary to another, and never remaining long enough in any one institution to receive any permanent benefit. Out of these one hundred and fourteen cases, but fifty of them remained for persistent treatment. Of the fifty, thirty-eight were markedly benefited; relieved in the same way as the above-cited cases.

Any accidents that may have occurred in the course of the treatment were due, at that time, to the lack of experience. To-day the system of treatment has been developed to such an extent that the indications and contraindications are distinctly set forth. This, of course, guards against the possibility of error and of accident. The treatment to-day, then, would naturally be more successful even than it was when Professor Charcot first exhibited it in Paris in the year 1888.

Following Charcot, Pierre Marie, in a work published by him on the diseases of the spinal cord, recommends it highly, especially for the inco-ordination of the gait, the fulgurant pains, and for the genito-urinary disturbances.

In the *Traité de Médecine*, a very extensive work, published



under the direction of Charcot and Bouchard in 1895, this form of treatment is most favorably recommended for the relief of the inco-ordination, the pains, and the genito-urinary troubles.

During the years 1896-97, while in Paris, pursuing the study of this subject, I saw many cases treated by suspension, and generally most favorable results followed its use. Within the past few days a patient told me that he received marked benefit from simply leaning forward and resting his elbows upon his knees. It was, in fact, the only means of relief he could obtain from the severe pains which he suffered at times.

Motehoutkowsky based the theory of relief, especially of the pains, upon the slight stretching of the nerve roots, much as the stretching of the sciatic nerve has been employed by surgeons for the relief of sciatica; while the relief of the other symptoms was based upon a modification of the circulation of the spinal cord. The treatment applied to the vigorous healthy subject produces a quickening of the pulse and a marked increase in the arterial tension. This increase of arterial tension, producing an increase of nourishment, would produce a greater resisting power on the part of the nerve-centres to overcome the disease.

In general, then, the indications for its use are: The inco-ordination; the excessive and persistent pains; the urinary disturbances; the loss of sexual desire, with shrinking of the parts; and the insomnia. These symptoms are all markedly relieved by the treatment of suspension. If this treatment, then, is applied in the early stages of the disease, it is quite possible, according to these authorities, to hold in abeyance the progress of this disease for many years. True, there are a certain number of cases in which the onset is by the more vital crises, in which this treatment cannot be used, but these cases come under the contraindications. If we have relieved the above symptoms the patient is at rest, and this is much. Among the contraindications we find: Organic disease of the heart, pulmonary tuberculosis, tendency to apoplexy, arteriosclerosis, general arthritis, the presence of laryngeal symptoms, obesity, emphysema, and, finally, a bad condition of the teeth. It has been demonstrated that in a certain percentage of tabetics a peculiar, degenerative change takes place in the teeth, by which the process of decay advances with but little, if any,

pain. These patients are frequently able to draw their own teeth with their fingers, and without pain. This process is explained by the changes in the trophic centres. These centres, lying, as they undoubtedly do, in close proximity to the more vital centres of the upper portion of the spinal cord, might precipitate a crisis of any of these centres, and disastrous results would follow.

And now, one word in regard to the description of the apparatus employed and the mode of its application :

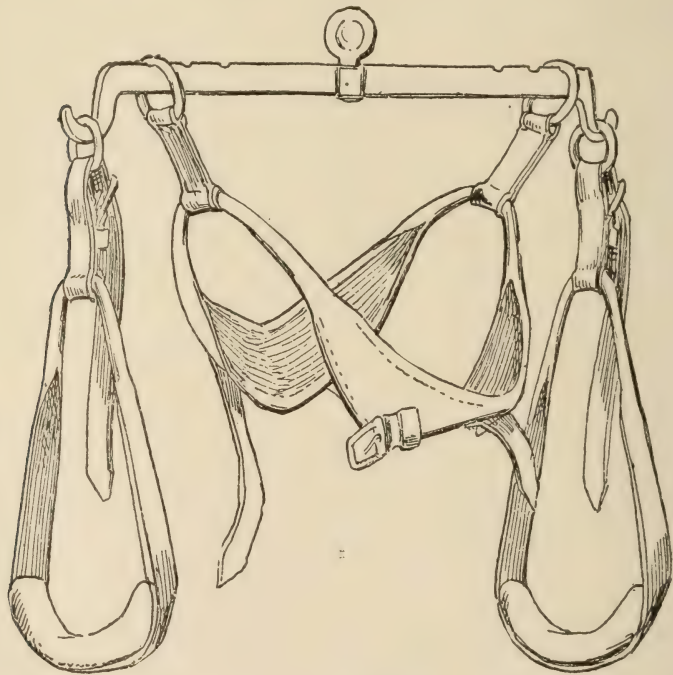


FIG. 1.—(After Charcot) Suspension Apparatus.

It is virtually the same apparatus as that contrived by Sayre, of New York, for suspension during the application of the Sayre Corset. It consists of a horizontal iron bar about eighteen inches in length, suspended by a ring in its centre, this being again attached to a pulley through which the cords or ropes pass which are used for its elevation. At each end of the bar is a hook, over which is hung a ring for the suspension of the patient's arms. Through this ring is drawn an adjustable strong strap, adjusted by means of a buckle and holes

punched in the strap. Suspended from this strap is a loop made of strong leather, rounded as it passes through the upper strap and flattened at the lower portion of the loop. The loop should be well padded, for the protection of the patient. Through these loops on either side the patient slips his arms, allowing the loops to rest in the axillæ until he can steady himself in the head-sling.

Upon the upper surface of the iron bar are cut, at either extremity, three notches a little distance apart. These notches are for the purpose of supporting, in a fixed position, the rings



FIG. 2.—(After Charcot) Apparatus for Head in Place.

which rest in them, and sustain the head-gear. Attached to these rings on either side is a strong double strap, made with an opening or loop at the other end, through which passes the loop which sustains the head. The head-loop is made of a very broad strap, rounded at each end, to pass through the opening in the strap attached to the bar-rings—broad and well-cushioned at those portions which rest under the chin and occiput. Attached to that portion of the loop which passes under the occiput, on either side, is a fixed strap which is intended to be drawn through a buckle attached on either side of the portion of the loop that passes under the chin. These straps are for



the purpose of fixing the position of the chin and occiput portions of the loop.

The entire apparatus is attached to a strong support above,

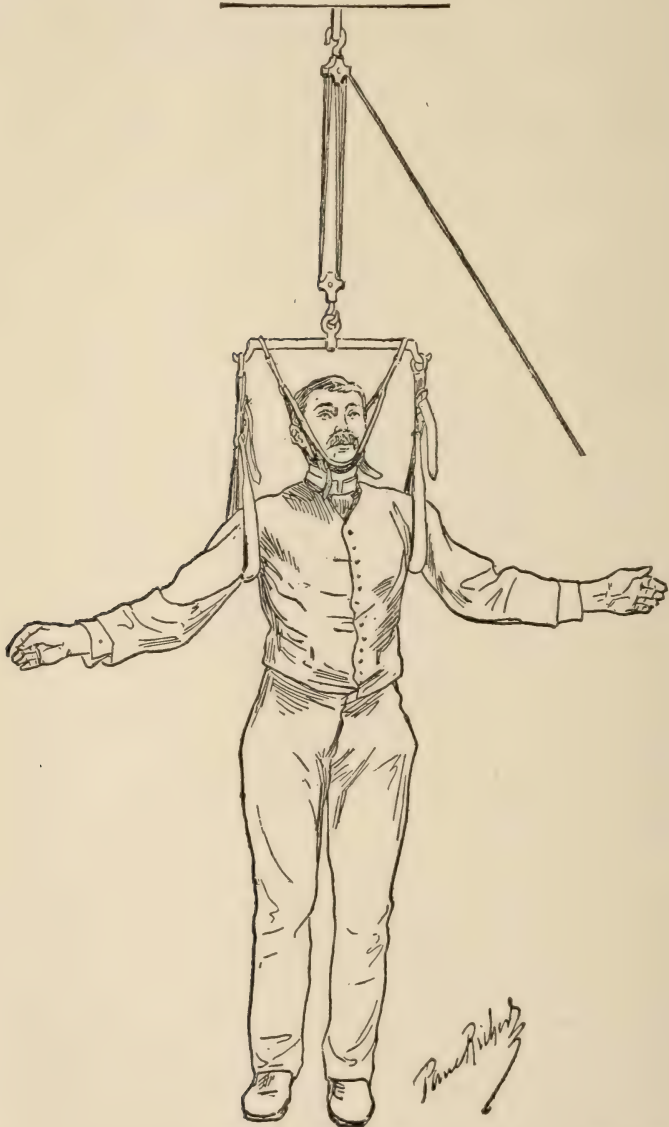


FIG. 3.—(After Charcot) The Suspended Patient, with Lateral Movements of the Arms.

and raised by means of a cord or rope passed through a pulley fastened to this support and another fastened to the apparatus.

The patient is now placed in position under the apparatus. The arms are slipped through the arm-loops; the head-loop is then carefully adjusted; the portion under the head carefully placed under the occiput, the chin-piece under the chin in such a way that it will be firmly fixed by the slightest pressure, but far enough away from the neck that the throat and great vessels of the neck shall not be pressed upon. It must be so placed that the respiration shall not in any way be interfered with. The arm-pieces should now be adjusted in such a way that the slightest elevation of the arms will permit the patient to rest in the head-sling. This is done by means of the strap and buckle that supports the arm-loop. The patient should now be raised until his feet are from three to six inches from the floor. Once elevated, the patient should gently raise his arms until the head easily and gently settles down into the head-loop. The suspension finished, the patient should gently lower his arms, that the weight of the body can once more be brought upon the arm-pits, and he should be lowered to the floor by the operator.

A little vertigo sometimes follows the first few suspensions, and in this case the patient should be allowed to rest in the sling for support until he can be conveyed to a seat. A few other precautions are necessary. Patients usually become so enthusiastic over the improvement that they beg for more frequent suspensions and of longer duration. But it must be remembered that at the commencement no patient should be suspended for more than one-half minute, gradually increasing as the patient can bear it; and they should never be suspended oftener than every other day, or every third day, if they do not bear the former well. Even those most advanced in the treatment do not bear the suspension well over three minutes.

The weight of the body, too, should be taken into consideration. A patient weighing from 125 to 150 pounds can be pushed more rapidly into treatments of longer duration: but those weighing more than 150 pounds should be increased very gradually, otherwise trouble will follow. The patient should suffer no pain, no exhaustion, from the operation.

The neck and arms should be free, the collar removed and the shirt unfastened; the arms, as well, should be made perfectly free by removing the coat and vest. The patient should in no way be hampered by clothing during the operation.

The accompanying illustrations will serve the description in demonstrating more perfectly the form and mode of use of the apparatus.

---

### INSTITUTE EXPERIENCES.

BY GEORGE B. PLCK, M.D., PROVIDENCE, R. I.

(Read before the Rhode Island State Homœopathic Medical Society, January, 1898.)

THE presentation of facts is more potent to dissipate error than interminable argument. The welfare of the whole requires sometimes the sacrifice of the individual. Recent utterances in our journals demand the immediate publication of certain matters that I had proposed penning at a far later date. Should my plain, unvarnished tale rectify any of the many gross misconceptions pervading the public mind concerning the management of the American Institute of Homœopathy I will consider myself amply recompensed for all adverse criticism, public and private, that shall be hurled upon me.

At this point, courteous reader, it is important you should know (if not already aware thereof) that I am a plain, commonplace, general practitioner; that I do not know enough of any subject to pose as a specialist therein, even had I been endowed with a natural aptitude therefor; that I am not the alumnus of any homœopathic college, large or small, but rather of an allopathic institution, and possibly its sole representative; that I hail from a State not noted for the number of its acres or of its Institute attendants; that I am neither a graceful orator, a wily politician, nor yet even ordinarily good-looking. It is also pertinent to state that my preliminary knowledge of the Institute was confined to a very casual inspection of its irregularly-paged, pasteboard-covered *Transactions*, a volume so unsightly and so positively repellant as to convince me the Society that issued it was utterly unworthy the patronage of a respectable practitioner. Its assemblage at Lake George in 1879, however, afforded a convenient opportunity to scan the beauties of that famous sheet of water and to discover what manner of menagerie would exhibit that year on its banks. I went, I saw, I was conquered, *completely*. The Institute fever seized



me; its throbbings continually disturbed my rest, while its annual exacerbations have been relieved only by meeting others similarly afflicted.

At Lake George I discovered it was considered a very proper thing to be a member of a bureau, or section, as it is now termed. A friend asked me which I preferred to serve on. There were but two on which I could work, sanitary science and obstetrics; between them I had no choice. So destitute was I of influence, however, that when the Institute adjourned I had received an appointment on neither. I tried to comfort myself with the reflection that my fate was good enough for me, that I ought to have known better than to attempt to ride two horses, but, in all confidence, will admit that I felt as blue as indigo, as mean as a whipped spaniel, and as weak as a half-drowned kitten. On the train back to Saratoga I chanced to sit near the late O. B. Gause, who had been appointed chairman of the Bureau of Obstetrics for the ensuing year, and with whom I was somewhat acquainted. I mentioned incidentally a project then under contemplation for sending a postal of inquiry concerning placenta prævia to every physician in Rhode Island, and reporting the result to my State Society. He promptly rejoined: "Why not let us have it? If you will, I will put you on my bureau." "All right," said I, beginning to feel somewhat encouraged. Then it occurred to me that if the national Society was to have the benefit of my investigation it ought also to be laid under contribution. The suggestion was made to Prof. Gause and promptly accepted, he authorizing me to issue the postals in the name of the bureau, provided he should first approve the proof. The final result can be ascertained by consulting the *Transactions* for 1880. Incidentally, it may be mentioned that was the only time postal cards were employed. The next year I introduced the style of circular familiar to all members.

Whether or not any of my reports to the Institute have been worthy the recognition implied by an appointment to a bureau chairmanship is a matter for others to determine, but if such there be, that first paper was certainly entitled thereto, for it is the best I have ever presented. At any rate, the honor then conferred secured for the Institute my best services for life. In those earlier days I used to get a chairmanship moderately fre-

quently, but now, as I am approaching seniority, and becoming somewhat fossilized, it is impossible for me to obtain a foothold in any section. It is just as well, for the remaining fields that I can profitably investigate are few and scattered, and their location altogether uncertain.

"But," snarls some constitutional growler, "you have had exceptional opportunities." Not a bit! One or more bureaus have been submerged during my time, and others have barely escaped shipwreck. Either one of these afforded for years abundant chances for any doctor, young or old, male or female, to make a brilliant reputation, had adequate energy and courage been exhibited. The fact is, quite a number of our members wish to see their names occupy prominent positions in the *Transactions*, although unwilling to exert or to inconvenience themselves in the slightest degree honestly to earn the coveted prestige. I have known one-half, and even larger fractions, of a bureau's members to fail its chairman, utterly oblivious of the fact that they were committing a gross breach of trust involving a direct insult to the person who reposed confidence in their promises, and to the Institute also, as well as disgrace to themselves, to the department in which they were enrolled, and to the general cause. Such recreancy is inexcusable. No person should accept an appointment in our national Society without appreciating the fact that by implication he pledges thereto his best mental fruitage for the year. Should any withering blight overtake him in the first six months, he should promptly resign his position to another; if in the last six, the harvest should already have been garnered.

Since an idea got abroad that my recommendation has some weight with the leaders of the Institute I have been requested semi-occasionally to secure bureau positions for doctors. When I considered the applicant promising I have labored for him, sometimes successfully. Those who performed the task assigned I have forgotten, but those who failed I still remember, feeling keenly their disgrace and mine. The good old Puritanic principle that he who does his duty deserves no credit, while he who does not merits exceeding blame, is especially applicable to this situation. One who has not occupied the position can have no conception of the difficulties besetting a chairman in his attempt to organize a reliable section. For

example, a certain lady practitioner, long since deceased, applied repeatedly to me for a position on the Bureau of Obstetrics. Although possessed of pronounced ability and an engaging manner, I hesitated lest the paper she should present would not be up to the standard. One day she casually remarked, "It is so nice to see one's name on the programme!" I promptly determined, if that was her idea of the duties and responsibilities of bureau membership, she should be left severely alone. However, at length one was found more impressionable than myself, and the coveted appointment was secured. Naturally, I was curious as to the outcome. About a month before the next annual meeting the lady appeared at my office and, after shaking hands, exclaimed, "Doctor, what are the sequelæ of puerperal convulsions?" "A wooden jacket, ordinarily," was my prompt rejoinder. "But seriously," she continued, "that topic has been assigned me and I want information concerning it." "Well, I don't know anything about it; I have never thought on the subject." "Perhaps some of your books contain something on the topic," she replied. "Perhaps so," I answered and commenced searching. After half a dozen volumes had been fruitlessly explored I gave up in disgust, remarking, "I am afraid I can do nothing for you." "But haven't you any other book that might refer to the subject?" she persisted. After a little reflection I continued, "Yes, there is a little French work on obstetrics, that came out some little time ago, in Wood's Library; that may contain something." Accordingly I hunted it up, turned to the index, and then joyfully exclaimed, "Ha! I have it." On the designated page was a paragraph of some six lines containing the whole matter in a nutshell. Reading it aloud, she noted the various disorders mentioned and then carefully catechised me as to the method of their derivation, jotting down such remarks as seemed useful. She bade me good-bye with thanks and an intimation that possibly she might call again. A week later she reappeared with the interrogatory, "What remedies would you give for these several disorders following puerperal convulsions?" "The same that I would give were they the original diseases. We prescribe for the condition we have before us irrespective of antecedent circumstances." "But what would you give for this, and this, and this?" naming the different sequelæ, "and why would you think



of the several remedies?" she asked. When she had been satisfactorily answered she departed with another package of notes. With mingled feelings I looked forward to the reading of her paper. When called upon she commenced, "Circumstances beyond my control have prevented my giving this subject the consideration its importance demands," and I quietly smiled. Listening carefully to her entire essay, however, I decided that I was satisfied therewith; she had brought no discredit upon herself, and therefore none upon the bureau. I congratulated her upon her success, for she deserved it. Married at an early age to a man for whom she did not care, because her mother advised the step and assured her she never could do better, she received blows from his hand less than six weeks thereafter and endured the pangs of starvation before the advent of her first-born. Temporarily separated, she yielded to his promises of reform, but left him forever prior to the appearance of her second child. These she brought up and educated well, meanwhile studying medicine and establishing herself in a remunerative practice. Having accomplished so much, it was but natural she should aspire to higher fields of labor and to wider distinction.

While few, if any, men would express their heart's desire in the same terms as she whose record has been briefly sketched, it by no means follows her thought is a stranger to their crania. They simply resort to other means to secure their ambition. Quite a number of years ago so much complaint was made that only a "*favored*" (?) few could secure bureau positions that formal action was taken to abolish the alleged evil. I chanced to be one of the victims of that movement, and therefore retain vivid recollections thereof. The members were invited to send to the Secretary a list of the bureaus they desired to serve on, with the order of preference. How many responded I know not, but I distinctly remember that very soon after my appointment as obstetric chairman my friend, T. Franklin Smith, stuck a list of twenty names, more or less, into my face, with the *pleasing* (?) announcement that three names at least *must* be selected from that paper, and that the Executive Committee desired that more should be taken. My first impulse was to ask him who was to be responsible for the bureau of obstetrics at the next session, he or I, but finally I

concluded to accept the situation and to observe carefully the experiment. Critically scanning the submitted names, I derived just as much information as I would in perusing the Directory of a city I had never visited. I knew no better who would give me a creditable paper, who would disgrace my bureau, who would fail me utterly, and who, *if any*, would work at all. But nine appointments were to be made, and to risk more than one-third of them on absolute strangers was not to be thought of. Accordingly my bureau was framed as directed, the selection of the novices being determined largely by geographical considerations, subjects were assigned, and the result awaited with trepidation.

Two months before the annual meeting the first paper came in, and it was from one of the strangers. With it was, a personal note authorizing me to add to, subtract from or amend to any extent that my judgment dictated. That, of course, was read first, and then the essay. When the latter was completed I was *sick*! There was absolutely nothing in it! "Will the others be like it?" was my first despairing cry, and "What *shall* I do with *this*?" my second. I read it to a gentleman whose kindness of heart and sound judgment is unquestioned, carefully concealing the authorship, of course, and he promptly said, "Toss it into the waste-basket!" This advice did not satisfy me exactly, so I took it to J. C. Budlong, more recently a Vice-President of the Institute, observing the same precaution. He said, "It depends upon who the writer is. If he is a young upstart crowding his way along, sit down on him as heavily as you know how. If he is a middle-aged practitioner who accepted his appointment in good faith and has done the best he can, it is your duty to see him through." "That is just my way of thinking," I replied; "I don't know how old he is, but he accepted the appointment in good faith. If anyone is to blame in this matter it is myself for tamely submitting to dictation in the constitution of my bureau." "Then you are bound to help him out," he rejoined. Accordingly, availing myself of the gentleman's courteous authorization, I struck out of his paper everything but the opening and the closing sentences, with such characteristic expressions as were scattered through it, and then put a body into it, carefully avoiding any phrase that might suggest my editorship. The paper was re-

turned to its author with the remark that I had availed myself of his kind permission, and now desired his final revision. It came back with the statement that it was so different from its original form that he had nothing to offer. Other papers having been received meanwhile, I copied a number of them, that my chirography should not give us away, and all were finally presented, discussed, and printed, as usual. But this was not to be the last of that essay. Some months afterward I picked up a magazine containing an article by one of the most prominent men in our school. In it he referred to the paper in most flattering terms, making special mention of the long experience and careful observation of the author. Now, if my name had appeared at its head he never would have paid that tribute to its worth, for I did not worship at his shrine. Hence, when reading it, I shook with illy-concealed merriment, and soliloquized, concerning my fortunate colleague, "Some men are born great, some achieve greatness, and some have greatness thrust on them." The possibility that he may still be inhabiting this sublunary sphere prompts me to suppress his theme. It was so difficult, however, I never would have dreamed of grappling with it under other circumstances.

Two other *brief* reminiscences will suffice. A young man with a diploma a year old and a paper he desired to see in the *Transactions* was once presented to me with the request that I give him a chance in my bureau. Learning that he had already been elected to membership, I at once examined his essay, accepted it as a volunteer contribution, and permitted him to read it after the regular papers had been disposed of. The ensuing year he was attached to the Bureau of Surgery. On another occasion I appointed a lady to the Bureau of Obstetrics ten minutes after her election to membership in the Institute. We were strangers up to the time I tendered her the position, though during the session, whose closing hour was just at hand, I had kept her under observation, and, as I believe, accurately estimated her mental calibre. Ere vernal blossoms decked again the earth she was sleeping beneath the sod, and our sisters were robbed of one who would have enrolled herself among their proudest representatives.

While it is unlikely that another would have deported himself exactly similarly in the designated premises, it is certain



that I have sufficiently indicated the sentiments that would prompt the action of most in similar circumstances. I have listened to too many reports (in private) concerning their editorial functions to entertain doubt upon the subject. Neither does it accord with human nature to decline presenting to the Institute a second Helmuth, or Allen, or Ludlam. Furthermore, those of us who have toiled and sacrificed for homœopathy a score of years or more, realizing, meanwhile, the imperfection of our work quite as accurately as our critics, are keenly sensible our strength will tarry with us but little longer; and anxiously do we scan the countenances of the recruits, asking among ourselves, Who will take our places and loyally serve when we are gone? Some of us may have been so frequently betrayed by the failure of men on whose solemn promises we had at least some grounds for reliance as perhaps to be unduly suspicious of all; but let anyone substantiate his word or hers by works, and appropriate recognition will be at once gladly accorded.

It is alleged that the Institute is governed by a ring. If so, I have failed to discover it, perhaps because I have never engaged in its politics, but contented myself with voting for the candidate I considered most entitled to any given position, all things being taken into consideration. It is true that here and there could be found a man who, I believe, used at times his public influence to gratify private malice; but the opportunities for such performances are rapidly decreasing, and such conduct will soon be impossible. I consider the Institute to-day as thoroughly democratic in its workings as is possible for an organization of its size and extent. This conclusion is the result of a somewhat careful scrutiny of men and events at its last nineteen sessions.

NOTE 1.—This article was written expressly for the HAHNE-MANNIAN MONTHLY in November, 1897, but was retained for a first reading at the annual meeting of the Rhode Island Homœopathic Society in January, 1898.

NOTE 2.—A letter received this day in lieu of a reply to my circular of the first instant impels me to place on record the following incident: At the St. Louis session of 1885 a paper

was read that differs considerably from my views on the subject treated. Three or more gentlemen discussed the theme in a similar vein, and the moment was fast approaching when a proper regard for truth would compel me (though in no degree an extemporaneous speaker) to attack the propositions presented, when a lady sitting directly behind me, but near the centre of the hall, arose, and in the allotted space of five minutes, with words of burning eloquence, prompted evidently by intense feeling, assailed the positions taken, exposed their weaknesses, and appealed to her associates to rally for the right. She took her seat amidst deafening applause, and the question was rapidly passed around the front seats, where I chanced to be located: "Who is she? Who is she?" "Dr. Smith—Julia Holmes Smith, of Chicago," was the response of the few who knew. Having been advised that I should be entrusted with the Bureau of Obstetrics during the ensuing year, I determined to secure her services if possible. At the earliest convenient moment I obtained an introduction to the lady, and ten minutes thereafter had her securely listed. Two hours later, Phil Porter tendered her a position on the Bureau of Gynæcology, only to find himself sadly left; and when President T. F. Allen announced the members of the Bureau of Sanitary Science (I believe), he read "Julia Holmes," and then exclaimed: "Oh, that name is crossed out!" *At least three invitations to bureau membership were received by a person who entered upon attendance at that session comparatively unknown!* From this fact the reader may deduce such conclusions as he can.

MARCH 14, 1898.

---

## THE ARTIFICIAL FEEDING OF INFANTS WITH SYNTHETICAL MILK.

BY C. SIGMUND RAUE, M.D., PHILADELPHIA.

(Read before the Trousseau Clinical Club, Philadelphia.)

A COMPARISON of the results obtained by breast-feeding and artificial feeding in the rearing of infants demonstrates conclusively that as ordinarily practiced the artificial method falls far from successfully imitating and supplanting nature's method. The question naturally arises: How do we account for this dis-

crepancy? And having discovered where the fault lies, we ask: Can the obstacle to successful infant-rearing by artificial means be practically overcome?

By a recognition of the three prominent factors entering into a thorough understanding of this most important subject we can, I believe, remedy all that is hurtful, and place ourselves in a position where we need no more fear the perils of weaning or the constitutional dyscrasie traceable to faulty nutrition.

Of these factors, the first resolves itself into a study of the chemical composition of human milk and a comparison of cow's milk and the various artificial foods with human milk.

The second and perhaps most prolific source of failure is the presence of micro-organisms in the artificial food, whereby access is given pathogenic and harmful fermentative bacteria into the child's economy. Referring to human milk, it is but necessary to remind ourselves of the fact that the secretion from the breast of a healthy woman is entirely sterile.

The third factor refers to the frequency of feeding and quantity for each feed. Exceptionally a breast-fed babe can be overfed; but as the breast requires a certain period of time for a restoration to its physiological state after having been emptied, and as the mode of feeding, the total satisfaction afforded the child by getting its nutriment in an easy, pleasant manner, of the proper temperature and taste, it soon becomes accustomed to stop when the stomach has received a sufficient quantity, falls asleep, and does not awaken until the stomach is in condition for a renewed supply of food to work on. This constitutes a normal appetite, the only condition under which normal digestion is possible.

The baby fed on insufficiently nutritious substitutes and indigestible paps, soups, and other pernicious substances, is not so fortunate, however. Hence it usually awakens before the regular time hungry and cross, or, disturbed by the pangs of colic induced by fermentation or the irritation of an indigestible food, soon makes its misery known by the cry of pain. It is immediately offered the bottle, and temporary amelioration sets in, for the simple reason that the ingestion of a warm fluid gives relief and the child's attention has been momentarily taken from its suffering. Shortly the colic returns with re-



newed force, and thus the vicious method of feeding the child every time it cries, or every time it awakens, is established.

These are the conditions to which the evil can be traced, and which we must correct in order to place the subject of infant feeding upon a scientific basis. They are absolutely under the control of scientific hygienic methods; and if we fail to grasp the importance of the subject, and allow child after child to succumb to avoidable causes, it is but a gross neglect on our part that will remain as a blot on the present era of medicine.

Human milk is a watery, bluish-white fluid of sweetish taste and alkaline reaction. Compared with cow's milk it presents a lower percentage of total solids; considerably less proteid matter, but a higher percentage of lactose and about the same amount of fat as the former. The greatest difference between the two, and the one of most practical import to the physician, is the disproportion in the amount of proteids, human milk containing from 1 to 2 per cent., while cow's milk almost uniformly contains 4 per cent.

Again, the proteids of milk consist of two nitrogenous bodies, lact-albumin and casein. The latter forms large curds when coagulated by the addition of acetic acid, while the former is not affected by this reagent. The proportion of casein to lact-albumin in cow's milk is 4.1; in human milk it is 2.1. Therefore, human milk contains not only a smaller percentage of total proteids, but the proportion of casein is one-half of that in cow's milk; and this accounts for the vast difference in the digestibility of the two milks, as the casein is the more difficult of digestion and forms the large curds vomited by the child, or the firm, tough, undigested particles so often found in the stool of hand-fed babes.

The table given below represents the average of a large number of analyses of human and cow's milk compared:

*Standard Comparative Table of Human and Cow's Milk.*  
(Cautley.)

	Cow's.	Human.
Water, . . . . .	87	87.46
Solids, . . . . .	13	12.54
Proteids, . . . . .	4.06	1.93
Fat, . . . . .	3.70	3.62
Lactose, . . . . .	4.48	6.75
Salts, . . . . .	0.76	0.26
Reaction, . . . . .	Acid.	Alkaline.

It has been stated that human milk is more variable in its composition than cow's milk, the deviation from the normal being great enough at times to induce considerable disturbance in the child's health. The reason for this variability is easily understood when we consider the influence of the nervous system upon secretion, both directly and indirectly, through alterations in nutrition. The ruminating cow, a fair representative of a tranquil mind, or rather a mind unsusceptive of anything but a momentary impression, can surely not be expected to show any marked deviation in its normal physiological functions when properly fed, as a dairy cow generally is.

The human subject, however, possesses a highly impressionable nervous system, and it is therefore not an uncommon thing for the various functions to be influenced by external impressions. Beside this, however, the nature of the diet, the amount of rest and exercise taken by the woman, and certain physiological states, such as the recurrence of the catamenia or pregnancy, must be taken into consideration.

Even under normal conditions the milk varies in composition, depending upon the way in which it is obtained from the breast. Thus the fore-milk is watery and poor in fat, the middle milk represents a fair average of the specimen, while the strippings are especially rich in fat. The interval at which the breast is emptied also influences the composition; the more frequently the breast is emptied, the more concentrated and consequently indigestible the milk becomes.

When the diet is highly nitrogenous the percentage of fat is increased; when an excess of fatty food is taken the fat is decreased, owing to the diminished metabolism.

With a liberal nitrogenous diet the proteids are increased, as well as the fat; insufficient exercise is also a potent factor in increasing the proteids.

The result of an excessive quantity of fat in the milk will be eructations; vomiting, which generally occurs during or shortly after nursing, the milk coming up uncurdled or containing small flakes of casein or fat particles; intestinal disturbances, and in extreme cases fatty diarrhœa. A deficiency of fat can hardly be said to induce constipation. V. and L. Adriance, in a report on the chemical examination of two hundred cases of human milk, consider the constipation as resulting from an in-

sufficiency of the solids of the milk generally. They cite the case of an infant which developed colic, vomiting, green stools, and a falling off in weight. An analysis of the milk showed 8.44 per cent. fat. The mother's diet and exercise were regulated, the fat fell to 3.40 per cent., and the child made a speedy recovery.

When the proteids are in excess there is vomiting, usually of large curds, colic, diarrhœa, stools green and containing tough, undigested curds, or obstinate constipation. Loss of weight will ultimately result.

Rotch reports a case in which an infant was given to a wet-nurse whose milk was well digested for a few weeks, when, owing to the liberal diet indulged in by the nurse and the insufficient exercise she was taking, the milk changed so in character that the infant began to vomit thick, tough curds. An analysis of the milk showed 4.61 per cent. proteids.

Lactose, the carbohydrate element in milk, shows very slight variations; but as carbohydrates constitute the chief element of most artificial foods, it is well to note the disturbance induced by excessive quantities of this food. Their chemical instability renders them especially liable to fermentation in the presence of micro-organisms. Lactose is converted into lactic acid, and cane sugar and starch into alcohol, acetic and butyric acid. Lactose is more stable than cane sugar, is the form present in nature's food, and is more available for assimilation than cane sugar. It should, therefore, always be given the preference in artificial feeding. We must, however, remember that much of the milk-sugar obtained in the shops is adulterated and is said to contain mucus; it is therefore imperative to use a thoroughly reliable product—such as is employed in the preparation of our triturations, for example.

When there is an excess of carbohydrates in the food there is a predisposition to colic and diarrhœa. Children fed over a long period of time with foods supplying this element, to the exclusion of a sufficient amount of fat and proteids, become large and flabby, and usually rachitic. Anæmia is a prominent feature, and their resistance to the invasion of disease is below par. This is beautifully exemplified in the condensed-milk babe. There is a condensed milk, however, which does not present these disadvantages. It is, more strictly speaking, an



evaporated milk, rich in fat and not preserved with cane sugar, and, being absolutely sterile, offers many desirable features as a temporary expedient in emergencies. I refer to the Romanshorn (Swiss) evaporated milk.

The percentages of proteids and fats in breast-milk can be readily varied by regulating the mother's diet and exercise, as has already been pointed out. In artificial feeding it is a still simpler procedure. There are many methods of modifying cow's milk to resemble human milk in chemical composition, but they are usually complicated, require a large variety of stock solutions to be kept on hand, and considerable skill in their preparation. For a simple practical method, very successful in the average normal case where but a slight modification of the milk is necessary to overcome the indigestibility of the casein and to furnish a sufficient amount of fat, I must refer you to the procedure recommended by Henry N. Guernsey as far back as 1867, in his work on *Obstetrics* (p. 622).

When a more exact procedure is indicated, and where it is necessary to experimentally determine which element is excessive or deficient, or having determined this and decided upon the proper percentages to be employed in the case, I would recommend the method which I have devised for use in my wards at the Women's Homœopathic Hospital. Owing to the simplicity of this procedure it is also well adapted for general practice, and is offered without hesitation.

The following table, giving the total quantity for twenty-four hours and the interval for feeding according to the different ages, has been constructed according to the metric system, to simplify matters in compounding the feeding-mixture.

*Time and Quantity for Feeding.*

Age.	Quantity.	Interval.	No. of Feeds in 24 Hours.	Total Quantity.
1 week.....	30 c.c.	2 hours.	10	300 c.c.
2 to 3 weeks.....	45 "	2 "	10	450 "
4 weeks.....	60 "	2 "	10	600 "
2 months.....	90 "	2½ "	8	720 "
3 "	120 "	3 "	7	840 "
5 to 6 months.....	150 "	3 "	7	1050 "
7 to 9 "	180 "	3 "	7	1260 "
10 months.....	200 "	3½ "	6	1200 "
12 "	240 "	4 "	5	1200 "

To begin with, we must have our stock solutions to represent a definite percentage of the proximate principles entering into the formula. Skimmed milk is used to furnish the proteids, and knowing that cow's milk, especially when representing that of several cows, contains almost uniformly 4 per cent. of proteids, we base our calculations upon this analysis. Besides the proteids it contains 4.5 per cent. of lactose, which must not be overlooked.

Centrifugal cream contains 20 per cent. fat, and is to be used to supply this element. Besides this we will need sugar-of-milk, lime-water and plain boiled water. Having decided upon the formula to be employed in a given case we proceed to calculate the percentage of each element necessary, and having determined the percentages, it will be a simple matter to estimate the number of cubic centimetres of each solution necessary for making up the total quantity for twenty-four hours, as indicated in the table given above. As an example, we will take the following recipe :

	Per cent.
R Proteids, . . . . .	1.33
Fat, . . . . .	4
Lactose, . . . . .	7
Reaction, . . . . .	Slightly alkaline.

The skimmed milk has been shown to represent 4 per cent. proteids, therefore it will require  $33\frac{1}{3}$  per cent. to furnish the  $1\frac{1}{3}$  per cent. of proteids for the recipe. Besides this, however, it contains enough lactose to contribute  $1\frac{1}{2}$  per cent. toward the mixture ( $\frac{1}{3}$  of  $4\frac{1}{2}$  per cent.). To bring the lactose up to the amount indicated in the recipe we will have to add  $5\frac{1}{2}$  per cent. more.

Cream containing 20 per cent. fat must constitute 20 per cent. or one-fifth of the mixture to furnish 4 per cent. of fat. So far our calculation reads as follows :

	Per cent.
Skimmed milk, . . . . .	$33\frac{1}{3}$
Cream, . . . . .	20
Lactose, . . . . .	$5\frac{1}{2}$
Water, . . . . .	$40\frac{5}{8}$
Total, . . . . .	100

When it becomes necessary to render the mixture alkaline,

one-fourth of its bulk of lime-water is usually added. In this case, the bulk of the milk and cream together represents  $53\frac{1}{2}$  per cent. of the total quantity of the formula, consequently 13 per cent. of lime-water will be the proper quantity in this case. Substituting the lime-water for 13 per cent. of the plain water in the prescription, it reads as follows :

	Per cent.
Skimmed milk, . . . . .	$33\frac{1}{2}$
Cream, . . . . .	20
Lactose, . . . . .	$5\frac{1}{2}$
Lime-water, . . . . .	13
Water, . . . . .	$27\frac{5}{6}$
Total, . . . . .	100

This mixture closely resembles mother's milk, although slightly below the average in proteids, for which reason, however, it is well borne and digested by young infants. As they grow older the proportion of proteids should be raised to 2 per cent.

Putting this method to a practical test, we will consider the case of a child ten weeks old, and by referring to our table we learn that it should receive about one hundred cubic centimeters at each feed. By simply translating the percentages into cubic centimetres it will be an easy matter to compound the prescription, and in the case of the lactose, it is weighed out in grammes.

This paper does not pretend to go into the subject farther than pointing out the principles underlying infant feeding, by which we may recognize the needs of the growing organism for each of the proximate principles represented in a perfect food for infants, and also know when one or more are in excess or not digested, besides demonstrating the *modus operandi* of preparing such a food according to the indications present in each case. By a careful study of this subject, and the adoption of an accurate, scientific method in carrying it out, we will be enabled to make it as useful and exact a branch of medicine as our *materia medica*, which likewise is based on careful experimentation and observation in both the healthy and diseased organism, and must be applied singly to the study of each individual case.



## EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

## THE ARMY AND NAVY FOREVER.

THE advice is good: In time of peace prepare for war. For us homœopaths, at the present time, In time of war prepare for peace, is better.

The present seems an opportune time to press for that recognition by the Government of the United States and by the State authorities in appointments to the army and navy, which has so unjustly been withheld.

Various spasmodic efforts have been made in times past to secure a categorical statement as to the position taken by the United States Government on the question of granting graduates of homœopathic colleges the right to be examined for commissions in its service, but without avail. If we are not mistaken, the last answer rendered was to the effect that liberty of application for position would be accorded to graduates of any regular college; but the word "regular" was not further defined, and was supposed to have been used in the arrogant sense once so common, but now so nearly obsolete, of allopathic.

The question is now being taken up by several of our medical bodies throughout the country; and, if agitated and prosecuted in the proper manner, is, we think, in a fair way of being decided more favorably to us than heretofore.

In making our appeals to the authorities for recognition, we think our representations should take a somewhat different form from that in which our demands for separate examining boards were couched. There the establishment of separate boards could in no way work injustice to individuals, but, on the contrary, was the only way in which such could be prevented. In the case under consideration the circumstances are different. Even granting, as we must, that a large percentage of those enlisting in the army or navy would prefer to be treated according to homœopathic principles, it would hardly

be possible to find all or even a majority of those under a single medical or surgical control having such preference; and compulsory homœopathic treatment of an allopathic majority would be quite as unjust, if not more so, than the forced allopathic treatment of a homœopathic minority.

The reference to any individual preference is, we think, a two-edged sword, which cannot be used to advantage in defence of our position. It would virtually compel in all medical posts a duplicating of the medical and surgical officers; and, in fact, if the eclectics should demand their rights too, even a triple set of officers, a manifest impossibility, or a division of the army and navy into allopathic, homœopathic and eclectic divisions, a still more manifest absurdity.

Again, we very much doubt whether any large number of would-be volunteers would be deterred from offering their services to the Government by the unwelcome prospect of being subjected to allopathic treatment should they become sick or be wounded, since such eventualities seldom enter into the calculations of those fired with patriotic impulses.

We are happy to be able again to draw attention, as we have repeatedly done on other occasions, to one great potential good that has resulted from the legal establishment of medical examining boards.

Our position on this question has been misunderstood and often misrepresented. Although we maintain that the original purpose of the movement which resulted in their formation was not to elevate the standard of medical education, was not to protect the dear public, but, first of all, to limit the number of homœopathic physicians, according to the candid utterances of some of its originators, and then of physicians in general, we have never failed to recognize the good that has been done by them. Evil was intended, but good has resulted. We are and have been concerned mainly in seeking to limit their activity within its legitimate sphere. One of the benefits following their creation—and in fact perhaps the greatest, for the others might have been gained by other means—is the fact that all those who have passed these boards are placed, in the eyes of the law, on the same footing; they all occupy the same position legally, and the term “regular” has been sent to the “demnition bow-wows,” where it has ever belonged.

It is along these lines that our present efforts at governmental recognition should be directed. The establishment of these boards, no matter how constituted, has at the same time established the principle that the Government does not arrogate to itself the right to prescribe, or to recognize, or to favor any method of practice, but has only to demand that those who are about to treat the sick for pay should be qualified to do so by a certain amount of knowledge of the science and art of medicine. The licenses issued by these boards to those who have successfully passed their examinations certify that they are thus qualified, and are therefore, in the true sense of the word, "regular." On this qualification alone we should base our claims to recognition. As soon as we appeal to individual preference, or to distinctive methods of treatment, we, by implication, acknowledge the right of Government to take cognizance of these, and, according to our line of argument, that is a point of view which we should take every opportunity to discountenance. We should base our claim to recognition upon the fact that we are both *de jure* and *de facto* qualified physicians, and, as such, possess certain rights and immunities common to all other physicians, amongst which is the right to place in the service of the Government if needed and if found competent. We demand, therefore, the right to be examined for position. If we fail, turn us down—not for the name we bear, but for the incompetency we show.

Additional force is lent to this argument by a consideration suggested to us during the Commencement exercises of the Hahnemann College of Philadelphia.

The diploma there given confers by its charter the degree of Doctor of Medicine, and the graduates differ legally in no respect from the graduates of the so-called "regular" institutions. In addition, not in place of this, they receive the degree of Doctor of Homœopathic Medicine.

It might seem that in advocating a line of action which calls for a setting aside of the name homœopath, we were not consistent with the views expressed two months ago, when we insisted upon our duty to retain the name; but the inconsistency is only apparent. Then we urged sticking to our colors in our position before the public, with whom lies the right of choice of treatment; here we maintain our claim to the



more comprehensive term, "qualified physician," before the Government, to which we deny any right of preference as to method of practice.

We have always regarded the name "physician" as the ideal, and we trust that a time may come when all seekers of the truth will unite under it; but it must be upon a higher plane than that occupied at present by the profession at large. In the face of an enemy we would never abandon our standard; but let that enemy become our friend, we will willingly unite with him, under some nobler title, in our efforts to reach a common goal.

During the "late unpleasantness" we could not have expected the surrender of the designations "confederates" and "northerners;" but now, united against a common foe, we find both going forth simply as American citizens, a higher, nobler title than any based on sectional interests.

Let us then storm the citadel of bureaucratic prejudice as physicians, not as homœopaths, urging no claims as favors to ourselves, to our clientele or to tax-payers, but demanding from the Government, both State and general, the rights which the logic of past events has undoubtedly given us.

---

#### THE AMERICAN INSTITUTE AT OMAHA.

THE next session of the American Institute of Homœopathy will be held at Omaha, Nebraska, Thursday, June 23, 1898, the materia medica conference holding one session on Thursday afternoon, and the opening exercises of the Institute being held in the evening.

The Local Committee, consisting of Omaha physicians and the members of the Institute living in the vicinity, has been at work with characteristic western energy, and has with great skill arranged for every possible need of the Institute, and for the comfort and pleasure of visiting members and their guests.

The sectional programme is complete, and promises well for the highest possible development of the scientific work, some of which will be unusual and unique, and calculated to awaken the interest of all attending members.

The work of the Section on Clinical Medicine for the year 1898 will be in the nature of a radical departure from the time-honored custom of the Institute. The increasing complaint that the number and tediousness of the papers presented, and the infrequency and insufficiency of discussion, has led the members of this section to meet the issue by abandoning altogether the presentation of papers in this section, and substituting in place thereof three live subjects for discussion.

Other sections have adopted novel methods for presenting the scientific work, and the outlook for satisfactory results in this line at Omaha is particularly promising, and will claim and deserve the largest attendance the Institute has ever had. Many papers of unusual merit are to be read and discussed, so there will be no possible opportunity for lagging interest.

The outside attractions are unusual. The great Trans-Mississippi International Exposition, the most pretentious project ever undertaken by the mid-west, will be in full swing, and will present endless entertainment and instruction for all visitors, illustrating, as it will, the wealth-producing power and the extent of productive industries of the greater West.

The excursions planned for after the sessions of the Institute are tempting, offering the greatest possible attractions in grandeur of scenery to be found in an exploration of the globe. One goes through the heart of the Rockies to Salt Lake City and return, and the other to Yellowstone Park. The railroad fare from points east of Chicago and St. Louis will be a rate and a third; west of these points, one fare for the round-trip. The hotel accommodations of Omaha are ample and exceptionally good.

The western men have the success of this meeting at heart, and have spared no pains or effort to clinch it. Dr. Wm. H. Hanchett is travelling in the East at present, at great inconvenience to himself, for the purpose of arousing increased interest in this section of the country. And every member of the Institute should exert himself to appear at Omaha in person, bringing a new member for the Institute with him, and give evidence in this way of his appreciation of the untiring devotion of the Local Committee to the interests of the American Institute of Homœopathy.

## OUR GRADUATE.

PASSING out from an air redolent of sheepskin and an atmosphere heavy with valedictory advice, our hopeful graduate steps lightly into his little skiff, ballasted with the aggregated wisdom of a four years' course, and pushes out into the unknown waters of the future. God speed him!

The figure is old and worn; let us try a newer one.

Courageously he mounts the gilded bicycle of his hopes, with thoroughly furnished repairing kit, and pedals forth determined to do a century and with the centurians stand; may he long be spared a punctured tire. He goes forth not alone but by hundreds, yea by thousands, to possess the land. The almost universal verdict is that there are too many of him. Some few optimistic statisticians point to the hundreds of little towns and villages still unprovided with homœopathic physicians, but that is not whither our graduate is going. His wisdom and skill, purchased at such an outlay of time, energy and money, are not to be wasted within so narrow a sphere; they need the cities for their exhibition and the cities need them, and thither they carry them.

How often, alas, are tires punctured and riders disabled before the century run has been made!

The tendency is too much city-ward, and yet how much speedier and surer the limited competency offered by a less ambitious practice. One's wealth depends not upon his income but upon his wants. The limited income derived from a country practice brings greater independence than the larger receipts from a practice in the city, in all but exceptional cases.

Besides this, the mental growth of the bright graduate in the country is in the direction of a wider, fuller development than in the city, where, surrounded by specialists on the right hand and on the left, and by those in front and behind who are ready and willing to be called into consultation, he soon loses the self-confidence with which he left the sheltering arms of his Alma Mater, and fails to develop that self-reliant and resourceful spirit which characterizes his brother in the country, thrown for the most part upon his own responsibility.

We would therefore advise our graduate, for his own good, both pecuniary and mental, to turn away from the large cities.



The health and the lives of the dwellers in the country are just as valuable to their possessors and just as well worthy of their best skill and wisdom.

---

#### THE GOLDEN JUBILEE OF OLD HAHNEMANN.

MAY 11 and 12, 1898, were red-letter days in the history of Hahnemann Medical College of Philadelphia. The Educational Congress and the Alumni Reunion (extended notices of which will be found in the news pages of this number) brought together an unusually large number of old graduates and many visiting physicians from all parts of the country to do honor to the fiftieth anniversary of the mother of colleges, and to fittingly celebrate the Jubilee occasion by an intellectual repast of educational topics, led and participated in by homœopathic college teachers and others equally interested in maintaining a high standard of medical learning. The college, true to her historic record, was found to be quietly leading the van in all things pertaining to the highest possible development of medical students, and the interchange of thought and opinion of these two days' sessions will have a profound influence in all educational matters for years to come.

The evening of the 12th was given over completely to the Alumni Association, and, amidst surroundings of elegance and luxury, four hundred of the alumni and their guests sat down to a banquet, teeming with enthusiasm and ringing with eloquence that will long be recalled with pleasant memories. It was a fitting climax to a splendidly successful celebration.

---

**MYRRH IN THE MIXED INFECTION OF DIPHTHERIA.**—The Berlin correspondent of the *Therapeutic Gazette* says that the mixed or secondary infection of diphtheria, which is known to be complicated with pus germs, is now very successfully treated in that city by tincture of myrrh given in doses of about 1-100 of a drop at frequent intervals. The writer accounts for the curative action on the ground that as in all pus cases we find leucocytosis, and as it has been shown by Biaz and others that the white blood-corpuscles are increased four times by the use of tincture of myrrh, therefore, in accordance with a well-known law, tincture of myrrh in minute doses, frequently repeated, may arrest the trouble.—*Medical Times*, May, 1898.

## GLEANINGS.

---

**THE HARD PULSE.**—Dr. W. Janowski, of Warsaw, Poland, in a study of the diagnostic and prognostic importance of the exact examination of the pulse, states, with regard to the hard pulse, *pulsus durus*, that its elevations resemble the vibrations of fiddle-strings. It may be either very large or very small, and with a little practice one may detect it even if it be filiform, though generally it is not always a slow pulse—*pulsus rarus*. In youthful individuals it is observed with hypertension of the arterial system, of which the most frequent causes are arterio-sclerosis and nephritis; meningitis—chiefly of tuberculous origin—is the only infectious disease accompanying it. Lead-poisoning is the principal toxic cause. Of itself the pulse is not of diagnostic importance. In children a differential diagnosis between lead-poisoning and nephritis should be made by examination of the urine. If fever be present, then meningitis must be excluded. In valvular heart diseases the presence of a hard pulse is well-known.—*Wiener Medizinische Presse*, No. 16, 1898.

Whenever I meet with such a pulse, I generally think first of chronic interstitial nephritis, but for the sake of thoroughness examine the heart, arteries and urine. A very important point to remember is that a patient with chronic interstitial nephritis may at one visit present a fairly frequent and hard pulse, while at other times the pulse may be fast and of a much lower tension. Chronic interstitial nephritis is not always accompanied by a urine of low specific gravity. A patient may be passing a subnormal quantity of dense urine and yet be suffering from chronic interstitial nephritis. Without microscopic examination of the urine one may be unpleasantly surprised by a uræmic convulsion.

**VENÆSECTION IN URÆMIA.**—Prof. S. B. Laache, of Christiania, Norway, in a paper read before the last International Medical College, at Moscow, claims that under certain circumstances bleeding may be a very powerful means of restoring the secretion of urine in cases of uræmia, of which he gives the following example—calculous anuria: No urine had been passed for six days, the pulse was very tense, the pupils contracted ad maximum, the sensorium clouded, the face greatly congested, and even swollen, but otherwise no œdema. A circulatory obstacle seeming present, venæsection was done and improvement immediately followed. A short time after the patient began to urinate, and in a few days he was temporarily restored to a fairly normal state, temporarily.

The writer also mentions two other cases of typical uræmia with general spasms which ceased after venæsection, the one immediately and the other after several hours. In one of the cases eight litres of urine were passed in twenty-four hours, and the pulse was, at once, after bleeding, paradoxical. In the other the pulse became very rapid and soft. In the first-mentioned

case about a litre of blood was drawn, the patient being plethoric. He asserts that if one will influence the circulation one should bleed with a free hand: from five to six hundred grams will suffice. Though thus he would unload the overburdened heart, yet he also, with Leube, thinks that venæsection exerts a "depurative action on the system."—*Norsk Magazin for Lægevidenskaben*, No. 3, 1898.

I have obtained good results in coma of uræmic origin with hydragogue cathartics, and, above all, with croton oil, in one- or two- drop doses. This drug will brighten up a stupid uræmic for a day or so and bring about a wonderful improvement, for a time.

**DIAGNOSIS OF WHOOPING COUGH.**—Prof. N. Filatow, of Moscow, points out several diagnostic points that may serve one when a child with pertussis be seen, and yet no coughing attack happen to occur when the physician be present. These are: the appearance of the patient, the ulceration of the frenulum linguæ, and the peculiar character of the urine.

The child's face, from the repeated coughing attacks, is swollen, œdematous, especially around the eyelids. The conjunctivæ are hyperæmic, and may be the seat of capillary hæmorrhages.

The ulceration of the frenulum is of great diagnostic importance, for it is nearly exclusively observed in whooping-cough. It is due to friction of the tongue on the lower incisors during the coughing attacks.

The author confirms the researches of Hippicus and Blumenthal, who had noticed that pertussis patients have a *pale* urine of *high* specific gravity,—1022 to 1035, according to Vogel's urinometer, while normally it is usually 1010 to 1012—and contains a great quantity of uric acid. The latter, being but slightly soluble, forms a crystalline and whitish deposit. These pathognomic signs appear early in the urine, and even before the characteristic attacks of "whooping."—*La Settimana Medica*, No. 16, 1898.

The red eyes—hyperæmic conjunctiva—are serviceable early signs of the disease.

**INDICANURIA IN DISEASES OF CHILDREN.**—Dr. Concetti, from numerous observations, concludes that indicanuria is very frequently observed in diseases of the digestive tract, in those acute or chronic infections that decrease the resistance of the organism, as tuberculosis, anæmia, serophulosis of the lymph glands. A great degree of indicanuria indicates, according to Jakseh, that in some parts of the body a decided decomposition of albumin is going on. Such a state may occur under toxic influences of infectious origin in the tissues themselves, or from digestive disturbances.—*La Pediatria*, Nos. 1, 2, 3, 1898.

**A CASE OF GUMMA OF THE BASE OF THE BRAIN.**—Dr. Dydynski, of Warsaw, Poland, reports the case of a woman 46 years of age, who came under observation in a semi-unconscious state, with difficult speech of a nasal intonation; normal temperature; left-sided hemiplegia, with right-sided hemiparesis; double paresis of the inferior branches of the facial, with possible greater involvement of the right side; deglutition very much impeded; conjugate deviation of the eyes to the right; the pupils slightly dilated and reacting normally to light; the cutaneous and tendinous reflexes were abolished; sensibility very decidedly diminished in the arm and leg of the left



side; the bladder and rectum functionated normally; every ten to fifteen minutes there were attacks of convulsions in different groups of muscles, more frequently in the right lower and the left upper extremities. The first convulsive attack was followed by paralysis and loss of consciousness, which occurred the previous evening. Her history and personal antecedents led him to think of syphilis. A diagnosis of a gumma of the brain was made, and situated probably at the base of the brain in the meninges, and pressing on the lower part of the protuberance and the upper part of the medulla, above the decussation at the pyramids. The right side was evidently most compressed. The convulsions resulted from irritation of the motor fibres. Antisyphilitic treatment brought about rapid amelioration, so that after seven weeks there only remained a slight weakness of the left arm.—*Przegląd Chirurgiczny*, tom. iii., Zeszyt 3.

**EARLY PATHOGNOMIC SIGNS OF TABES DORSALIS.**—Prof. Bechtereff calls attention to several diagnostic signs of tabes that are to be detected before abolition of the tendon-reflexes. One of the earliest is exaggeration of the cutaneous reflexes, abdominal and epigastric. Anæsthesia of the cubital, peroneal and popliteal nerves is characteristically absent in the early stages. Biernatzky has called our attention to the painlessness of the ulnar (cubital) nerve in early stages of tabes, but Bechtereff claims that if one half-flex the leg on the thigh, one may then easily compress the popliteal nerve, and elicit possibly an early sign—analgesia—of the disease. In the early stages, if one squeeze the muscles of the arms, and especially of the legs, which, normally, is painful, in a tabetic this sensation is dulled.—*Anales del Circulo Medico Argentino*, No. 3, 1898.

FRANK H. PRITCHARD, M.D.

**THE IMPORTANCE OF CILIATED CELLS.**—How often has the physician stood by the bedside of a very young child with a catarrhal pneumonia, or only simple bronchitis, and seen it drowned in its own secretions, because of the opium in some patent cough syrup, or, in some instances, due to his own ignorance or carelessness—the cilia of infants being especially susceptible to opiates? Is it not possible that the pneumonia that sometimes follows the prolonged administration of a general anæsthetic may be due to the complete paralysis of the cilia—thus allowing the diplococcus pneumoniae to reach the very alveoli of the lungs? Perhaps it may be well to add that this germ is found in a large per cent. of healthy mouths. The leucocyte has been well described as an armed soldier, ever on the lookout for stray enemies; but what a life of ease and comfort compared to that of the ciliated cell! Let these cells pause for even a short while, and we would be afflicted with some deadly disease or drowned in our own secretions. All honor to the little soldier who, from the moment of his birth, falls into the ranks and offers a hand-to-hand conflict with myriads of foes. The respiratory tract may well be the Thermopylae of our existence, and is being invaded at every inspiration; nature did well to put in the front ranks not leucocytes but Spartans.—Dr. W. R. Aylett, in *Virginia Medical Semi-Monthly*.

**THE BACTERIOLOGY OF RHEUMATISM.**—(MM. Triboulet and Coyon.)—After studying many cases of rheumatism to discover the presence of the bacillus of Achalme in the blood of the living subject of rheumatism, these authors have

examined successively a rheumatism of fifty-four years not treated, a young woman of nineteen years not treated, a choreic of thirteen years, affected with transient articular affections, but with fever; a case of thirty-three years, violently attacked, and treated unsuccessfully for three weeks with salicylate of soda internally and salicylate of methyl by local applications, and in the course of which grave complications of pleurisy and pericarditis supervened, with profound constitutional effects; and, lastly, the blood of a choreic child of eight years, with fever. Five examinations of the blood of the different subjects of rheumatism were made, and in every one, without exception, the authors were able to isolate and cultivate a special micro-organism—a diplococcus, identical in every case, and completely different from the bacillus of Achalmé.—French Letter, *Medical Times*. WALTER F. BRIERLY, M.D.

NOTES UPON THE TONGUE.—In examining the tongue by inspection, more importance should be attached to the appearance of the posterior surface than to the appearance of the tip. The coatings of the tongue in disease are mostly due to two causes. First, partial disease permits the mucus and exfoliated epithelium to accumulate; second, the poison engendered in the system resulting from pathological conditions is conducive to an overgrowth of the constituents of the coating. The coating of the tongue is not so much a criterion in gastric trouble as is usually supposed. Dryness of the tongue is often due to the patients lying with the mouth open. Nothing produces dryness of the tongue, lips and mouth sooner than a sudden dehydration of the body. This accounts for the dry tongue and thirst in diarrhoea and excessive vomiting. The unnatural flow of fluid in diabetes produces the dryness of the tongue and the thirst that usually accompanies that disease.

A slowness in protruding the tongue, or the catching of the tongue against the teeth of the lower jaw when attempting to protrude it, may be due to apathy, general prostration, paralysis, or stiffness from desiccation.

A unilateral coating may be due to a diseased tooth or to hemiplegia which prevents the coated side from being cleaned by movement. The parrot tongue is long, narrow, and of peculiar roundness when protruded, denuded of epithelium, bleeding and red. It usually denotes severe visceral disease, such as hepatic abscess, carcinoma, dysentery, peritonitis, deep formations of pus, as in the ulcerative stage of typhoid fever. The tongue in diabetes is much like this and very dry.

A tongue that is too clean or of a crimson redness may accompany an irritable stomach of tubercular enteritis.

Paleness of the tongue is significant of anæmia, especially chlorosis and acute anæmia from hæmorrhage. In acute dyspepsia due to atony the tongue is usually coated white.

In case a child, with suspicious symptoms of diphtheria, who is naturally unyielding and rebellious, refusing to “put out the tongue,” becomes willing to have his mouth and throat inspected, the suspicion of diphtheria is much strengthened.

The smoker’s patch is a plaque on the anterior portion of the dorsum, to one side of the median line. It is raised, not ulcerated, but red and irritated.

The appearance of the tongue and mucous lining of the mouth is not an indication of the condition of the lining of the stomach, as is often asserted.—*The Medical Counselor*, February, 1898.

**SOME DIARRHOEAL DISEASES IN CHILDREN.**—In a paper read before the Medical Society of the County of Erie, Dr. F. H. Stanbro, Springville, N. Y., outlines the medicinal treatment as follows: If vomiting is constant, get the stomach quieted before giving any laxative, although 1-10-grain tablet triturates of calomel sometimes seem to act as a sedative and laxative too. He advises the withholding of nourishment, even water, except in small quantities, for six to twenty-four hours. For intestinal disinfection he gives calomel,  $\frac{1}{16}$ -grain, four to six times daily, for a few days. He also advises salol, naphthalin, resorcin, tannic and gallic acids combined with bismuth subnitrate, but he says: "The remedy which has been of the greatest aid to me is arsenite of copper. There is no drug which appears to help so many physicians, and, again, fails to have any effect in the hands of others, as this drug; but in my hands, dissolving a 1-100-grain tablet in water, 4 ounces, giving 1-drachm doses every fifteen minutes, until an hour or two has passed, then continuing the dose every hour, gives good results. The stools improve in character, their number is lessened, and griping ceases within twelve hours."—*Buffalo Medical Journal*.

W. D. CARTER, M.D.

**HEREDITARY SPASTIC PARAPLEGIA.**—Dr. Weston D. Bayley, of Philadelphia, records in the *Journal of Mental and Nervous Disease* (November, 1897) a unique series of cases. For at least five generations various members of a certain family have been afflicted with an apparent primary sclerosis of the crossed pyramidal tracts. Nine cases came under Bayley's observation, in all of whom there developed about the fifth year, without previous ill-health, spasticity of lower limbs, increased knee-jerk (one exception), ankle clonus, and more or less tendency to talipes. In none was there static ataxia, pupillary changes, sensory, bladder or bowel symptoms. The wonderful similarity of the cases, both as to time and mode of onset, absence of sensory phenomena, and (with exception noted) state of reflexes, establishes its hereditary type. It is obvious, therefore, that another congenital affection must be placed in the lists with the already well-known Friedreich's ataxia and pseudo-hypertrophic paralysis. From these two hereditary diseases it differs in the most obvious manner. Nor has it more than a cursory resemblance to the spastic paraplegia of infancy, which is cerebral in origin, involves the upper extremities with the lower, presents cerebral symptoms, and is believed to be absolutely non-hereditary. It would be of great interest to know the pathological condition in these cases; whether the lesion originates in a vascular defect or is primarily inherent in nerve tissue. This, in the absence of opportunity to examine the cord, must remain conjectural. It is worthy of note, however, that in this family the escape of an individual from the affliction seems to confer immunity upon his or her descendants, the affection travelling in direct and not in collateral lines.

F. MORTIMER LAWRENCE, M.D.

**SURGICAL HINTS.**—Never allow rubber plaster to come in contact with a surface uncovered by normal skin. Since it cannot be sterilized by heat, it must be considered as being dirty.

Before operating, always find out whether the patient has any malarial history. The discovery of this fact will save you many a bad scare when temperature rises suddenly after operation.



As long as any urine issues from the urethra, it cannot be said that there is an impassable stricture. Patience and gentleness will do wonders. The most skillful surgeons see very few strictures which prove impassable.

An aseptic dressing placed over a wound which is expected to unite by first intention should be left undisturbed until it is time to remove the stitches, or until there is reason to believe that the case is not running the expected aseptic course.

If you find albumin in the urine before operating for pelvic trouble, remember that it may be due to cystitis, and not to a nephritic condition. Investigate microscopically, or by catheterization of the ureters, if possible. Albumin does not signify much if casts are persistently absent.

Wherever large wet dressings are indicated for a long time, we often find that all the antiseptics now in use may cause an eczematous condition of the skin, unless so diluted that their antiseptic power is more than doubtful. In such cases the employment of a simple saline solution is frequently of the greatest value; cutaneous irritation seldom follows its use, and wounds do as well as with any of the antiseptics.

Do not cauterize infected wounds unless it is to obtain a moral effect in a scared patient. It was shown that more than fifty years ago that when horses were inoculated with glanders, and sheep with pox, cauterization with a red-hot iron, applied ten minutes after inoculation, failed to check the disease. An infected wound should simply be well laid open and covered with a wet dressing. The use of nitrate of silver to cauterize wounds is a harmful absurdity.—*International Journal of Surgery*.

H. L. NORTHROP, M.D.

DIAGNOSIS OF DISEASES OF THE UPPER RECTUM AND SIGMOID FLEXURES. —For all tumors, then, or all pathological processes attended by increase of size and induration, this (bi-manual palpation) is still the method of diagnosis to be chosen first of all in either sex. The next step forward was made when Kelly found that a perfectly straight tube sixteen inches in length could be passed its whole length into either the male or female bowel, and the mucous membrane projecting over the end illuminated by electric light so as to be sufficiently clear to enable the examiner to detect a pathological change. The sigmoid is large and its walls project over the end of the tube, and only the projecting part can be seen as the tube is withdrawn. Whether this is the front, back, or lateral wall, I have never been able to decide in any one examination, and having fortunately detected diseases confined in a circumscribed spot by one examination, I have been unable to get the same point into the field a second time without repeated subsequent examinations. This can be avoided by substituting for the Kelly tube a modification of my own, in which the end, instead of being open, is closed by a plug of hard rubber, properly rounded, and the opening is a fenestrum in the side. This fenestrum is closed by a movable sliding door. The instrument is introduced its whole length with the fenestrum closed. The slide is then withdrawn to any desired length, and an opening remains in the side of the cylinder through which a good view can be obtained. In this condition the instrument may be rotated so as to bring into the field the complete circumference of the bowel at any desired height.—Dr. Charles B. Kelsey, in *Medical Brief*, May, 1898.

**LACERATION OF THE CERVIX.**—Dr. Theophilus Parvin, of Philadelphia, in the *International Medical Annual and Practitioner's Index* for 1898, contributes on abstract of an article by Lutaud on lesions of the cervix, in which occurs the following interesting paragraph on laceration of the cervix: Whenever the patient's consent can be obtained, Emmet's operation for repair of the cervix should be performed. Many patients, however, will not allow an operation, and in these cases medical treatment should be tried. The author recommends that a two inch bougie containing five grains of aristol made up with powdered gum arabic should be introduced daily into the patulous cervix, and retained in position with a cotton-wool tampon. It should remain for twenty-four hours, and then the cervical canal must be syringed with a solution of salicylic acid (salicylic acid, 4 parts; spirits of lavender, 30 parts; water, 450 parts. Two tablespoonfuls to be added to a quart of water), and a fresh aristol bougie introduced.

**SURGICAL HINTS.**—In bullet-wounds penetrating the brain beware of much probing. The chances are usually that the course of the ball cannot be followed through the soft brain tissue.

In operations on the fingers, toes and penis, it is frequently better not to use constriction above the seat of operation. The bleeding can well and rapidly be controlled, and there is usually less subsequent oozing.

In the operations for empyæma, general irrigation of the cavity is a dangerous measure, which has several times been followed by considerable depression of the vital powers. It is not to be used unless the pus is decidedly decomposed.

In fracture of the patella, do not adopt incision and wiring as a routine treatment. One or two bad results will soon abate your enthusiasm. Try everything else first, and let the operation be a last resort in case of non-union.

It is usually inexcusable to neglect skin-grafting in cases in which it is indicated. If the patient or his friends do not wish to contribute, the skin of small mammals and frogs has been used with success, and, even if a small percentage of the grafts finally take, it is all gain and no loss.

General anæsthesia may often be dispensed with in cases in which its use seems, at first sight, to be clearly indicated. It is always bad practice to subject a patient to unnecessary risk, however small.

The infiltration method and the use of freezing mixtures have a much wider field than is commonly thought to be the case.

In penetrating wounds of the abdomen never trust to the subjective symptoms. An insignificant injury, such as that caused by a small bullet that fails to enter the peritoneal cavity, may be followed by symptoms of great apparent severity, while a wound that must prove fatal without surgical interference may give rise at first to very slight general disturbance.

In both men and women in the healthy state, the urethra in a certain number of cases contains pathogenic bacteria. This is naturally more common in women. In cases of surgery about the pelvis or rectum, in which catheterization is likely to be needed, the first indication next to a sterile catheter is to begin, before the operation, the administration of remedies to make the urine bland and non-irritating. Where this is a routine practice, bladder complications are of great rarity.—*International Journal of Surgery*, April, 1898.

**METATARSALGIA.**—Dr. McCurdy, of Pittsburg, quoting Robert Jones, of Liverpool, says: "I believe that clinical observations accord much better

with a theory of treading upon, rather than with that of pinching, a nerve, and am fortified in this opinion by three anatomical facts: (a) The proximity to the painful area of the communicating fourth branch of the superficial division of the external plantar. (b) The collapse of the anterior arch in most of the cases. (c) The bulk of superincumbent body-weight in walking on the toes is borne on the first and fifth joints."

*Treatment.*—Treatment of plantar neuralgia must vary with the stage of the affection. In the first stage the patient will do well to take the warning given, and by appropriate precautions prevent the development of the affection. This is done by attending to the following details: (a) To abstain from continuing any action which produces the pain. (b) To increase the depth of the inner aspect of the heel in order to produce slight inversion of the foot. (c) To wear thick soles, with well-fitting insteps, and roomy around the heads of the metatarsals. (d) To insist that the sole be at least one-quarter of an inch thicker a little behind the base of the metatarsals.

The preventive methods as applied in the first stage should also be directed to the cure of the second stage, with certain additions, which may be any or all of the following measures: (a) A thick bar placed about a half-inch behind the metatarsal heads. (b) A band of non-irritating plaster around the instep. (c) Massage of the foot, with contrast baths of hot and cold water. (d) Elevation of the foot of the bed during the night.

In the third stage of the affection nothing short of an operation is satisfactory. By this I do not mean that on no occasion can an advanced case be relieved by mechanical measures. On the contrary, it can and often is. But operative measures are so safe and simple and other measures so prolonged and troublesome, that most patients do not hesitate which course to accept.

Of operations, three are radical and efficient. (a) Excision of the metatarsal head. (b) Excision of the joint. (c) Amputation of the metatarsal head and toe.

Short of these radical measures we may employ any or all of the following measures: 1. Actual cautery. 2. Heated needle into painful area to destroy nerve. 3. Hypodermic injections of carbolic acid. 4. Partial exsection of digital plantar nerve.

In making the incision its course should be crescentic, beginning in front of the metatarsal-phalangeal joint, and extending it around externally to this joint to a point immediately under the fourth metatarsal bone. The flap thus made can be dissected from the joint and such operation as necessary performed. The course of the incision throws the line of union between the fourth and fifth metatarsal heads, and thus avoids pressure upon the cicatrices such as occurs when the cut is made directly over the head of the bone.—*The Cleveland Medical Magazine*, March, 1898.

**THE CAUSES OF DIFFICULT DEFECACTION IN INFANTS.**—It is generally recognized as a fact that infants and young children strain at stool. The infant and young child strain at stool because of the imperfect development of the anatomic features concerned in the mechanism of defecation. These are:

1. The infant's lower gut is muscularly deficient.
2. Its mobility within the abdomen is obstructive to defecation.
3. The rectal valves are obstructive, and
4. The infant's anus, not being sufficiently expansible, is also obstructive to defecation.



The above points are well illustrated by twenty-four photographs and drawings which accompany the article.—T. C. Martin, M.D., in the *Cleveland Medical Gazette*, April, 1898.

WALTER F. BRIERLY, M.D.

**THE CONVERSION OF BROW-PRESENTATIONS INTO FACIAL BY TRACTION ON THE UPPER JAW.**—(Dr. Rose.) Brow-presentations may be converted into vertex presentations or facial presentations by direct pressure on the skull. The first may be accomplished either by pressing the occiput down into the pelvis from without, or, the hand corresponding to the face is introduced into the vagina, the brow pressed up toward the large pelvis, while at the same time pressure from without forces the occiput down into the true pelvis. This may be termed Beaudelocque's first method, which may be accomplished with the cervix but little dilated. Or, the hand may be introduced up over the occiput and the latter drawn down directly into the pelvis—Beaudelocque's second method, which requires nearly complete dilatation of the cervix.

The same principles have been applied to obtain a face presentation, either by pressure from without on the upper jaw, to force the face deeper into the pelvis, or, during a pain to press the occipital portion of the head up into the pelvis, and by fixation of it, the force of the pain drives down the face.

Collins formerly recommended the introduction of the entire hand up over the face, to seize the chin and to draw it down into the pelvis. The method employed by Dr. Rose differs from this, in that it is not necessary to introduce the entire hand, which is only possible when the head is movable, but instead only two fingers which do not seize the chin but are introduced into the mouth, and firm traction can be made on the upper jaw without taking up much space.

For convenience of description we may divide brow-presentations into three groups: 1st, the head movable or in the pelvic brim; so-called brow-presentation; 2d, the head fast in the pelvis; 3d, brow-presentation with threatened rupture of the uterus. It is taken for granted that the child is living.

If the head is very movable, Schatz's method may be attempted, as it does not require the introduction of the hand into the vagina; but, as in many years only three successful cases have been reported, it is liable to be unsuccessful. This group of brow-presentations appears peculiarly adapted to Thorn's combined method which includes both methods of Beaudelocque. If the occipital position is obtained but is not fixed by good pains, rupture of the membranes is often followed by good results. If the brow-presentation cannot be corrected, podalic version should be considered, especially in those cases in which former deliveries in breech presentations in contracted pelvis have been more favorable for the mother and child than vertex presentations. If there is irreducible prolapsus of the cord or small parts, or placenta prævia, the danger to the child calls for the termination of labor.

In the second group where the head is fast in the pelvis, Thorn's method appears to be the best; yet in many cases the successful result is to be ascribed to the employment of the first or second method of Beaudelocque, as frequently so much amniotic fluid has escaped that free movement of the vertebral column in utero is limited, and it is no longer possible to exert any influence upon the head fast in the pelvis. If Thorn's method fails, and also pressure on the occiput down into the pelvis with pressure upward on the

brow, there is left finally the drawing down of the occiput by Beaudelocque's second method; and if this method again fails, the conversion into a face presentation by traction on the upper jaw.

In drawing down the occiput or the face the hand should be introduced between pains and traction exerted during pains to obtain the best results. A better hold can be obtained through the mouth than is possible on the smooth round occiput, and the smaller anterior segment of the head comes down more easily. The second and third fingers can exercise powerful traction without compression of the cranium or enlarging the diameter of it, and this method is strongly urged before resorting to forceps. If the forceps are applied directly they should be in the oblique diameter of the pelvis, so as to bring the occiput posterior.

In the third group of cases, Thorn's method is contra-indicated. Beaudelocque's method is doubtful, but the face can be drawn down with reasonable safety as only two fingers are employed, which do not materially increase the resistance to be overcome. After the face has been brought down the forceps can be applied. If this method fails as well as the forceps, craniotomy is the only operation which remains.—*Centralblatt für Gynäkologie*, No 50, 1897.

THE DISINFECTION OF THE HANDS.—(Kronig and Paul.) They recommend the addition of hydrochloric acid to the permanganate of potash in proportion of 1 per cent. mixture of the permanganate to .4 of 1 per cent. of hydrochloric acid. This mixture is well borne by the skin, and only a slight odor of chlorine is noticeable. The disinfecting power exceeds that of a 5 per cent. solution of corrosive sublimate. The brown discoloration of the skin can be removed by oxalic acid in a short time. The advantage of adding the hydrochloric acid is in the development of chlorine, which is one of the most powerful oxidizing agents known, and a very effective germicide.—*Zeitschrift für Hygiene und Infektionskrankheit*, Bd. xxv., H. 1, 1897.

A PRACTICAL POINT IN THE TECHNIQUE OF ABDOMINAL SECTION — (Wendeler.) The writer has found that packing the vagina firmly in its upper segment is of great assistance in raising up masses from a small pelvis, and making them more accessible in operations from above. He has been surprised to see how very easily large myomas of the uterus can be lifted out of a small pelvis in this way with the patient in the Trendelenburg position. The uterine arteries are also more accessible, as the field of operation is lifted up and within easy reach.—*Centralblatt für Gynäkologie*.

GEORGE R. SOUTHWICK, M.D.

SYPHILITIC DISEASES OF THE EYE AND ITS APPENDAGES.—Henry E. Juler, F.R.C.S., of London, England in the course of the Harveian lectures for 1897 spoke as follows concerning chancre of the eyelid and its differential diagnosis: The preauricular gland is always enlarged, firm and painless, and not tender unless manipulated roughly. I know of no instance in which, in an undoubted case, the former was not perceptibly swollen and hard. The absence of tenderness has a diagnostic significance. The diagnosis of primary syphilitic sores in this region constitutes one of the most interesting problems in surgery. It may be mistaken for any one of the following lesions:

Rodent ulcer, epithelioma, lupus, chalazion, hordeolum and tuberculous ulcer of the prepebral conjunctiva.

Chancre of the eyelid is always accompanied by enlargement and induration of the preauricular or submaxillary gland, usually both; the absence, therefore, of glandular swelling will help to exclude many of the above affections. Thus, rodent ulcer, tertiary syphilitic ulcer, lupus, and in most instances chalazion and hordeolum, may be excluded, for in all of these the preauricular gland seldom if ever becomes enlarged.

I have known both eyelids removed for suspected rodent ulcer; the growth proved to be epithelioma, and yet the preauricular gland could not be felt. By the time that an epitheliomatous ulcer caused enlargement of the gland a chancre would have healed spontaneously and the sufferer be half through the secondary stage of syphilis. With suppurating chalazion and large suppurating styes the preauricular gland may be infected, but in some cases it is much swollen, painful, very tender, and the skin over it is red and œdematous. It is an acute lymphadenitis, easily distinguished from a chronic enlargement.

By a process of exclusion only one ulcer is left, the tuberculous ulcer of the conjunctiva, which is sufficiently rare to have been very much overlooked in literature.

In my opinion, this is the only ulcer that is likely to be mistaken for a chancre. The preauricular gland is firm and swollen, and the ulcer is either round, or oval and saucer-shaped.

Be suspicious if there is no induration at the base of the ulcer. A tuberculous ulcer, I have learned from experience, is never indurated.—*The Lancet*.

THE PSYCHOLOGY OF THE VISION OF CHILDREN.—In the *Psychologic Review* for October, 1897, Cathleen Carter Moore narrates the chronologic awakening of the complexity of functions that finally blend in form and color, vision and perspective. Her observations conducted on her own child are briefly as follows:

First Day.—The child opened its eyes only by a narrow crack; the eyeballs roll about in every conceivable position; pupils hardly affected by strong light.

Second Day.—Looked intently at a bright object and followed its movements.

Third Day.—Eyes wide open, but not co-ordinated.

Eighth Day.—Eyes seem to be co-ordinated for the first time.

Tenth Day.—Eyes often co-ordinate, even in the more complex movements.

Forty-seventh Day.—Observes things with interest.

Sixtieth Day.—Looked at strange faces seriously, but smiled at familiar ones.

Twelfth Week.—Would remain quiet an hour watching the trees sway in the wind.

Fiftieth Week.—Made grimaces at his own reflection in the mirror, and ceased when he saw by reflection that he was being observed.

Fifty-eighth Week.—Recognized a person he had seen for a few minutes three days before, but by whom he had been hurt.

One Hundredth Week.—Showed no preference for colored pictures over uncolored ones.

WM. SPENCER, M.D.



## MONTHLY RETROSPECT

### OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

---

**MEZEREUM vs. MERCURIUS.**—Hanchett, of Omaha, reports considerable success with mezereum in cases in which mercurius had failed. He believes that mezereum will cure more of the cases which may be described as a cross between syphilitic and mercurial poisoning than any other drug. Mercury has, through all time, been given so freely and frequently for all syphilitic troubles, indiscriminately, that there is often seen a condition hard to distinguish from a mercurial poisoning grafted on to a syphilitic constitutional disease. It is in cases of this class that he has found mezereum so useful. Nitric acid has been considered the great remedy to follow the abuse of mercury, but where that drug has failed mezereum gave good results.—*Medical Era*, April, 1898.

**GALLIC ACID IN PHTHISIS PULMONALIS.**—Lippincott, of Memphis, Tenn., has made a study of the literature of gallic acid, and as a result is persuaded that it is a remedy well worthy of trial in phthisis. The excessive expectorations of phthisis and bronchitis are, according to Hempel and Marcy, much lessened by gallic acid. The writer records no clinical experience of his own, however, and, in consequence, it is difficult to sympathize with his enthusiasm over the possibilities of the remedy.—*American Medical Monthly*, April, 1898.

**THE MEDICAL TREATMENT OF DIPHTHERIA.**—Dr. Byres Moir discusses the treatment of diphtheria in the London Homœopathic Hospital. The cases are too few to draw any definite conclusion from, but in the first series of thirty cases the death-rate was 33.3 per cent. ; in the second, 30 ; and in the third, 26.6 ; while in the last thirty cases treated in the hospital, thirteen without antitoxin and seventeen with, there have been only three deaths, two of the cases being moribund on admission, thus giving the death-rate at 10 per cent. In the hospital cases the treatment has varied greatly, but a large proportion have received mercury in some form or other, principally the cyanide or bin-iodide. The cyanide of mercury has a great reputation among homœopaths, striking figures of its success having been given by different observers ; but the writer and his colleagues have not met with the same success. Whether it is due to having a different class of cases or not, he cannot say. Nearly all the cases have been under ten years of age, and in nearly all the fatal ones the nasal and laryngeal regions have been attacked before admission. He has no doubt in his own mind of the value of the mercury salts, especially when the treatment is begun early, but he cannot look upon them as specific. For mild cases, where the septic condition is not well marked, we have good remedies in kali bichromicum, phytolacca, bromine and ammonia, but they do not meet the blood-poisoning ; and we naturally turn to

lachesis, crotales, and apis, all of which have rendered good service. They are of the nature of toxins. When there is present marked blood-poisoning, it must be difficult to stimulate the vital powers to react against the diphtheria poison, and a more rapid and better action might be obtained by administering them hypodermically.

In the writer's observation antitoxin has given far better results than we can get with any other drugs, and he has been struck with its action even when given in a late stage. Local treatment is still desirable, and signs of decided interference with respiration call for immediate tracheotomy. As to the sequelæ, in the nephritis we have sheet-anchors in cantharis, terebinth., apis and arsenicum : in the pneumonia, kali bichrom., phosphorus, and ammonium tart. ; while for paralysis, gelsemium, causticum, belladonna, and nux vomica. He particularly calls attention to the use of belladonna in paralysis of the respiration and heart.—*Journal of the British Hom. Society*, April, 1898.

THE TREATMENT OF POST-DIPHTHERITIC PARALYSIS.—Dr. C. L. Smith, of Chicago, reviews the semeiology of post-diphtheritic paralysis, and emphasizes the necessity of careful nutrition. Both as a remedial, preventive and nutrient tonic, he is devoted to the use of iodide of arsenic. Gelsemium stands at the head, sharing a tithe of its popularity with argentum nitricum. The former will prove more valuable if sensory symptoms are wanting and the paresis begins in the eyes. Conium mac is an analogue of gelsemium, to be consulted when the motor impairment spreads from below upward and is devoid of sensory accompaniments. Should the paresis have succeeded over-exertion or exposure to wet, rhus tox. is to be prescribed.

In the face of imminent heart-failure from intra- or extra-cardiac neural toxicity, hydrocyanic acid is most often indicated, and ammonium carb., glonoine, amyl nitrite, strychnia and strophanthus may be needed. The use of any of these should be accompanied with that of hot-water bottles and hot drinks. Inhalation of oxygen should be of service.

A compound remedy, original with the writer, in those cases of depressed vegetative or nutritive states, undoubtedly dependent upon trophic paresis, is phosphide of hydrastis, while chininum ars. is almost equally valuable. In neurotic cases that originally lacked a stable constitution zincum pic. has given good results.—*Medical Era*, May, 1898.

AMMONIUM CARB. IN URÆMIA.—Mifflin, of Baltimore, being struck by the view of Prof. Frericks, that uræmia is excited by the ammonia carbonica produced by the decomposition of urea in the blood, proposes the use of that drug where symptomatically indicated. In its pathogenesis he finds : forgetful, absent-minded ; confusion and dullness in the head ; gloomy, and depressed with frequent giddiness ; headache ; tearing pain in the head, with nausea and vomiting ; vision obscured, with bloodshot eyes, and often diplopia ; pale, bloated face, with eruptions and indurations ; no appetite, and continued thirst, nausea, vomiting and heart-burn ; cutting pain in bladder, with great pressure and frequent urination, urine containing sandy and whitish sediment ; shortness of breath upon exertion ; frequent palpitation, with hard, tense pulse ; excessive somnolence. This is a striking picture of uræmia. The writer has tried the remedy in four cases which presented these symptoms, in all with benefit. No permanent effect upon the kidney lesion was secured, however.—*American Medical Monthly*, May, 1898.

**PSEUDO-GOITRE OF HYSTERICAL ORIGIN.**—Halbert records the case of a woman of thirty-eight, whose physical misfortunes, added to a condition of hysteria, had made her almost a neurasthenic wreck. She would have periodic attacks of hysterical spasms so severe that muscular contraction would confine her to bed for a long time. After each of these attacks she observed a peculiar swelling in the thyroid region which lasted only a few days. Finally, it became partly permanent, though it always assumed larger proportions during the hysterical spells. It was doughy in feeling, pulsating, and at times red. Neither galvanism nor any of the iodides diminished its size or relieved it. She was then treated purely for the hysteria, being given the static breeze, and the valerianate of zinc, 3x, internally. Other remedies were used intercurrently, according to indications. No attention was paid to the goitre-like enlargement, but as she improved in general health, and as the neurasthenic symptoms disappeared, the goitre was reduced, and now there is no sign of it. There is little in our literature explanatory of such a condition, but to the mind of the writer it was a symptom of hysteria alone. The spastic irritation of the vaso-motor system, due to the hysterical loss of inhibition, would account for it. Had it not been treated as a nervous condition it is doubtful if it would have been cured, and in all probability connective tissue increase would have been the final result.—*The Clinique*, April 15, 1898.

**ANACARDIUM NEURASTHENIA.**—Halbert of Chicago, in the course of a clinical lecture, presented the case of a business man who, after years of conscientious effort, was suddenly discharged from his position. This preyed upon his mind so constantly that he not only suffered a mental decline, but presented all the features of a progressive neurasthenia. There were symptoms of inco-ordination, slight tremors, so that he could not write legibly, weakness of the sphincters, perverted reflexes, progressive loss of flesh and strength, insomnia, and all the peculiar parasthesiæ which generally attend the disease. He was given, somewhat empirically, strychnia phos., picric acid, and several other remedies, without the slightest relief. No form of electricity palliated. Finally, a more careful study of his symptoms elicited the following points: He complained mostly of his loss of memory and mental weakness; he said he could do nothing, because he was so absent-minded; there was a constant confusion and "emptiness" in his head; besides this, he became suspicious, irritable and anxious over the slightest detail; he would forget the simplest duty, and was filled with a constant despair. He complained, moreover, of a peculiar headache, as if something was plugged up so that the blood could not circulate. He also had an idea that his bowels were "plugged" so that they could not move, and there was a semblance of a similar constriction in the bladder and rectum. His breathing was difficult from a peculiar compressive sensation, and he was sure that he could not breathe or exercise the sense of smell, because of some stoppage in the nares. In addition, he experienced an itching sensation without any signs of eruption, and he complained also of great exhaustion, especially in the lower limbs.

All these symptoms were regarded as the natural features of neurasthenia, but there was so clear a picture of anacardium that that remedy was given in the third potency. There was almost an immediate improvement in every respect, and the patient is now nearly recovered.

Halbert considers anacardium our best remedy in cases like this, where the mental incapacity is pronounced. It is indicated particularly when the nerv-



ous depletion has come from "brain-fag," or over-use of the mind. It should, therefore, never be overlooked in neurasthenia. It represents the border-land between insanity and melancholia. The compression or "plug" sensation is no doubt due to excessive enervation in certain zones where the nerve-cells have been overused and hence exhausted. The general neurasthenia is a result of these local irritations and the constant depletion of the protoplasmic fibres of the cortex.—*The Clinique*, April 15, 1898.

**SELENIUM IN IMPOTENCY.**—According to Halbert, selenium is one of the most useful remedies in this unfortunate and generally overestimated disease. It seems to have more effect upon the mental phase of the disease than upon the cord incontinence. In a sense it is applicable where lack of confidence is a factor. In other words, this remedy is serviceable when the condition is due in the beginning to a loss of brain-control over the lower cord centre. Thus excesses are permitted from the want of mental regulation until the weakness of a pronounced debility is manifest. Later the debility is more marked, because the brain-cells are so exhausted that they cannot give any motor direction to the cord. It will be seen, therefore, that the leading characteristic refers pre-eminently to the mental process. The patient observes, first, a forgetfulness in business; the mind is active enough when pleasure alone is sought, but the moment that attention is directed to the daily duties the mind is indolent and unreliable. The mental faculties, on the contrary, are excessively active at night, and the patient is troubled with insomnia. All the symptoms are aggravated after sleep. As the impotency increases the mind dulness develops, until there is a general indifference and an insensibility to all surroundings. The bashfulness common to so many cases is not observed; the status is that of mental inability rather than timidity—stammering and imperfect articulation are leading symptoms. The bowels are constipated and the urine dribbles. The cause is from the same motor inability of the brain to control the cord. Such patients dwell upon lewd thoughts which the physical wreck cannot satisfy, and it is no wonder that this class of subjects increase the patronage of our asylums.

In conclusion, Prof. Halbert presents the history of a case in which the persistent administration of selenium brought about complete restoration of health.—*The Clinique*, April 15, 1898.

**IODINE IN GOITRE.**—Halbert records a case of goitre in a woman of twenty-four who had been treated for a long time by the local application of iodine tincture, with the only result that the tumor had gradually increased as the integument became hard and tender. The cervical glands were enlarged, evidently as a result of the continuous irritation of the iodine. There were some signs of tuberculosis, doubtful family history, unhealthy skin, considerable emaciation and profuse night-sweats. Galvanism gave negative results. Finally, iodine 3x was administered internally. In a few weeks improvement began, and now at the end of two years scarcely any tumor is perceptible. Two other members of her family, similarly afflicted, have been relieved by the same remedy. This experience, together with many similar ones, has confirmed the writer's belief in the internal use of iodine, provided it is used in potency and continued for a sufficient length of time. The external use is not sufficient, and there are no satisfactory statistics favorable to its use. Moreover, it is an irritant, and stimulates a fibrous increase rather than a decrease.—*The Clinique*, April 15, 1898.

F. MORTIMER LAWRENCE, M.D.

ON THE TREATMENT OF EPILEPSY.—Dr. Ballester Marin in managing epileptic cases advises the use of bell., cuprum met., plumb. metall. and curare. In the attack as palliatives he employs, as does Hughes, glonoine and amyl nitrate. "With these drugs one sometimes cures, frequently relieves and never poisons." The old-school drugs, bromides, in moderate doses depress the nervous system, and in large ones act as poisons.—*Journal Belge d'Homœopathie*, No. 6., vol. 4.

IODINE IN MILLAR'S ASTHMA.—Dr. Pinart, of Barcelona, in spasm of the glottis has noted, as many other writers before him have done, that it affects preferably those children with a tendency to become fat, a defective development of the osseous system, and an enlargement of the thoracic and cervical lymphatic glands. He has obtained good results with iodium in this disease, it acting both on the nervous system and the lymphatic glands. Calc. carb. and sulph. may be useful in certain cases. Lachesis is indicated where the attacks recur in spite of this treatment and if there be a tendency to chronicity with a general convulsive state.—*Revista Homœopática de Barcelona*, 1898.

SALVIA OFFICINALIS, SAGE, IN NOCTURNAL SWEATS.—Dr. Amado Gort records that Dr. Combemale, a homœopathist, employs this drug to combat the night-sweats of consumptives. He prepares the tincture by macerating one hundred parts of the flowers and an equal part of the leaves in five hundred gms. of alcohol. He administers ten to thirty drops of this tincture a few hours before the expected time of the appearance of the sweat. Under its influence the perspiration ceases and its action may persist for more than eight days.—*Journal Belge d'Homœopathie*, No. 1, vol. v.

Prof. Trousseau, of Paris, recommends this drug in immoderate and debilitating sweats—sueurs immodérées et débilifiantes. He also made a proving with an infusion of the leaves, which he records in his excellent work, *Thérapeutique et Matière Médicale*, vol. ii., p. 434, and on the next page proceeds to praise it for its antisudoral virtues, after having said that it is decidedly sudorific. "Ce fait n'a pourtant rien de contradictoire." . . . Van Swieten prescribed this drug in a wine, with success, in night-sweats, which so weaken those convalescing from fevers. I remember that I was often forced to drink bitter infusions—"teas"—of sage to break up "colds," and especially for debilitating sweats following a broncho-pneumonia, when a child. I have found opium, in the tincture, to be a very useful remedy in profuse sweating after typhoid fever. In a nun who was convalescing from an attack of grippe, and who was obliged to change her underclothes from five to seven times a day and night, morphine, one-fourth grain to four ounces of water, promptly caused the immoderate sweating to cease.

MEZEREUM AND ITS THERAPEUTIC SPHERE.—Dr. Puhlmann, of Leipsic, calls attention to the value of this now neglected drug which has been more or less pushed aside for mineral remedies. It has been very well proved. Its principal centres of action are the mucous membrane of the digestive tract and of the respiratory organs, as well as the skin. Secondarily, the urinary and sexual organs, the periosteum, the fibrous tissues and the nervous system are affected. The intercostal nerves are, of all the nerves, those most influenced, together with the trigeminus. A special indication is a sensibility of the patient to cool air; he shivers whenever a breeze strikes him. Further aggravation of the pains at night after becoming warm in bed, and nocturnal

itching, which is but little ameliorated by scratching. Most observers emphasize the efficaciousness of this remedy in tertiary syphilis, wherever mercury is without influence. It is especially useful in periostitis of the occipital bone and of the tibia, in neuralgias and herpes zoster.—*Leipziger Populäre Zeitschrift für Homöopathie*, Nos. 7-8, 1898.

It is doubtful whether mercury is much employed in tertiary syphilis. Iodine in one or another form is the accepted drug here. Dr. Donner, of Leipsic, in an excellent article on the late forms of hereditary syphilis, speaks of mezereum as serviceable in nerve- and bone-pains, especially of the occiput-dolores osteocopi.

Dr. Jonathan Pereira—*The Elements of Materia Medica and Therapeutics*, vol. ii., p. 418—says that a decoction of the bark of the root of mezereum was recommended to the notice of the profession by Dr. Alexander Russel—*Med. Observ. and Inquiries*, vol. iii., p. 194—as a very efficacious remedy in cases of venereal nodes and nocturnal pains. Again, he says: "But Mr. Pearson, after many years' observation of it, says, 'I feel myself authorized to assert unequivocally that the mezereum has not the power of curing the venereal disease in any one stage, or in any one form.'" Dr. Donner inveighs against attempting to cure syphilis with any other drugs than mercury and iodine, for from his extensive experience he has had some bitter *finis* disappointments, and especially in the hereditary late forms where delay may be fatal. A tincture of the berries is employed locally, in Germany, in neuralgias. It is said to resemble cantharis in its action on the kidneys. Dr. Burt—*Physiological Materia Medica*, p. 620—states that there are stitching and pulling pains in the kidneys, with crampy sensations before urinating, with bloody urine, as fresh and uncoagulated, but not so copious as that caused by cantharides. It also gives rise to albuminuria.

**THE THERAPEUTIC RANGE OF FERRUM PHOSPHORICUM.**—Dr. Nimier asserts that though this drug has quite a broad sphere of action it yet cannot replace aconite, for in acting on the blood-vessels, by paralyzing the vaso-constrictors, it gives rise to a full but easily compressed pulse, while that of aconite is as tense as a fiddle-string. Ferrum phos. is of service in congestive and inflammatory affections as soon as the excretions become streaked with blood or chocolate-colored, in whatever part of the body they be noted. It is of special value in summer diseases of children, appearing from taking cold after sweating.

*Meningitis* may be cured by ferr. phos. when the eyes are suffused with blood, the pulse full but soft, and the patient is relaxed and stupid. *Neuralgia* with violent headache which is throbbing, with relief from bleeding at the nose. Menstrual headache is amenable to the remedy. Neuralgia of the right supraorbital region, appearing in the morning. In habitually recurring epistaxis Dr. Cooper recommends the first dec. trit. (I have employed here the first trit. of ferr. mur. with fairly good results, but I eventually only brought about a cure by cauterizing the distended blood-vessels of a small and bleeding spot on the septum which destroyed the source of the hæmorrhage. A little trichloroacetic acid will do a great deal in these cases, the bleeding nearly always coming from a small area of the septum, which is easily detected by the rhinoscope. Prof. Verneuil, of Paris, some time ago called attention to the correlation of liver diseases and epistaxis.)



*Dyspepsia* is wonderfully under its control where the patient yearns for *cold water* or *brandy*, and abhors all meat—horror cranis—and milk. It might be thought of in the gastric disturbances of pregnancy. (A few years ago I translated an article from the Danish, for the HAHNEMANNIAN MONTHLY, on the use of ferrum in gastric affections.)

In dysentery, when the stools are watery and full of mucous shreds, and when the patient strains, *but without tenesmus*.

In the *summer diarrhœas of children* one finds it indicated where the patient vomits continuously, with watery and bloody stools, and the child decidedly emaciates within twenty-four hours. He then lies in a stupor, with a red face, half-opened eyes and dilated pupils; the pulse is full and easily compressible, and it throws its head continually from one side to the other, with sudden starting during sleep (acon.). Bell. is frequently prescribed in these cases. I must say that I have rarely been satisfied with its action. Baptisia will act well in such a state, if the stool is *dark, foamy, and of the color of prune-juice, and fetid*. Such patients, *if susceptible, may have terrible convulsions*, one after the other, even after the bowels begin to move freely, and there should be good drainage. If other remedies fail, I employ very small doses of chloral.

Congestion of the lungs finds a serviceable remedy in ferrum phos., and especially in secondary hyperæmia of the lungs, as a consumptive after taking cold.

*Articular rheumatism of the subacute form*, with aggravation from movement and amelioration from warmth.

*Anæmia* after calc. phos. *In all febrile conditions*, where there are circulatory disturbances, with an inclination to *hemorrhages*. Especially in the *hætic fever of phthisical subjects*. *In malaria*, after abuse of quinine, its use is often successful.—*Zeitschrift des Berliner Vereines Homœopathischer Ärzte*, xvii., Bd. Hft. ii., 1898.

SANGUINARIA IN HEMICRANIA.—Dr. Borrow reports a case of migraine in a woman who for three years had suffered from attacks coming on once a week, with nausea and vomiting, and lasting twenty-four hours. They began in the morning, increasing gradually in violence, being aggravated by movement, noise and light; sleep brought relief, though it was not always possible. Sanguinaria 9x was prescribed, and after some time the seizures left, no longer to reappear. She has been free for a year.—*Rivista Omiopatico*, No. 4, 1898.

Dr. Puhlmann—*Handbuch der Homœopathischen Praxis*, p. 485—recommends sang. 2x, in sympathico-tonic migraine, especially when the pain begins in the occiput, and passes over into the forehead, and is worse towards noon and evening, while lying down renders it more tolerable, especially in women with profuse menstruation. With similar pains and greater involvement of the eyes, and even painfulness, gels. 3-6x or spigelia 3x may be useful.

FLUORIC ACID IN SUPPURATION OF BONE.—Whenever, in a case of suppuration of osseous tissue after the administration of silica, the remedy's usefulness seems exhausted, and the case stands still or becomes worse, then one may obtain success with fluoric acid 6x or calcarea fluorata 3x, two to three doses a day.—*Revista Homœopatica*, 3, 1898.

FRANK H. PRITCHARD, M.D.

# THE HAHNEMANNIAN MONTHLY.

---

JULY, 1898.

---

## SOME FALLACIES.\*

BY ELDRIDGE C. PRICE, M.D., BALTIMORE, MD.

It is a fallacy to think the universe has but one centre; there are as many centres as there are human beings. Each human being sees the universe from his own standpoint, and from no other; and from this standpoint everything that *is* proceeds. Much that I have observed and experienced you have also observed and experienced, but much more I alone of all creatures, and you alone of all creatures, have observed and experienced, which is our individual experience solely. This experience I can give to no one, nor can you. It is this individual life which goes to make us what we are. To *me*, one of *your* most sacred truths is a fallacy; to *you*, *my* household gods are but gilded toys. Who shall arbitrate? Not our neighbor, for he *knows* we are both wrong; nor yet our neighbor's neighbor, for he is no more qualified to see through another's eyes than are you or am I. In very truth arbitration is impossible; we can but have charity one for another.

To-night, as I call your attention to some beliefs that are to me fallacious, I am throwing myself upon your charity, just as

---

\* Read at the annual dinner of the Hahnemann Club, of Philadelphia, Pa., April 12, 1898.

you would have a right to appeal to the charity of your fellows were you in my position.

The first fallacy which strikes my fancy to present is the present practicability of the "totality-of-symptoms" idea. "The totality of the symptoms must be the sole indication to direct us to the choice of a remedy"—*theoretically*. The assertion cannot be applied in practice. Why? Because it is not possible to possess ourselves of *all* the pathology and *all* the objective and subjective symptomatology of the patient, and to this picture apply a drug which has been known to produce in the healthy experimenter a similar condition in all its minutest details, *its minutest details*. Mark this fact: There are *two* totalities to be secured, not *one*. We may make application of an approximate similitum, but no man has yet intelligently, with scientific prevision, applied the *perfect* similitum, and until this is done the totality idea will remain but a beautiful theory, an ideal to be attempted, but not a demonstrable fact.

It is a fallacy to imagine that *all* the sins of the fathers are visited upon the children unto the third and fourth generations; sometimes hydrargyrum obliterates all signs before the arrival of even the *second* generation.

It is fallacious to assume that we can obtain a correct idea of the pathogenesis of a drug by proving on an approximately healthy experimenter—unless that prover be subjected to a thorough physical examination, and also keep a detailed health record for a reasonable time prior to the proving.

It is a fallacy that drugs always produce aggravations when given in material doses, even when indicated homœopathically.

It is a fallacy for a man of *one* idea to think he can develop *five* ideas at the same time; he may make a success of one of the ideas, but the other four will be failures. One may know something about everything and everything about some one thing, but it is fallacious to imagine one can know everything about everything.

It is a fallacy that drugs contain a dynamis, unless we include chemical compounds—dynamite for example.

It is a fallacy that drugs act; no drug has yet caused an effect upon a cadaver; it is the living organism that acts.

It is a fallacy to consider the present system of medical examining boards a success; the qualifications of the student



should be known *before* his *alma mater* gives the degree, and he should not be held responsible for his foster-mother's shortcomings. The State Medical Examining Board holds the graduate responsible for the defects of his college, and may grant him the right to practice medicine in *one* State only; the National Board of College Inspectors would hold the *college* responsible for its own defects and grant the graduate the right to practice in *every* State in the Union. Let us ask the American Institute of Homœopathy to use its persuasive powers with the Government for the establishment of this just system of medical legislation.

It is fallacious for an editor to think his readers consider him a great man because he is continually finding fault with his betters; a rational critic and a querulous fault-finder are not the same.

It is a fallacy that alternation means damnation; it simply means ignorance; and the man who does the criticising should first give us a more reliable *materia medica*, and also be sure he has no pet therapeutic sin of his own.

It is a fallacy to assert that the 30th dilution will inevitably produce pathogenetic results. First consider the Thuringian provers, the Milwaukee Test, Dr. T. F. Allen's experiments, besides making a few tests, before becoming dogmatic.

It is a fallacy to suppose that because a 30th dilution will make the sick well, it will make the well sick.

It is a fallacy to imagine the average man is trying to convince you of truth; he is merely trying to win you to his way of thinking.

It is a fallacy to regard apis as homœopathic to corneal ulceration; it was the sting of the wasp that produced this condition, which is sometimes credited to apis by symptomatologists.

It is a fallacy to think one can understand a drug and its therapeutic possibilities by memorizing symptom-cards.

It is fallacious to assert that it is the "depth of stupidity to make our five senses the measure of existence." Many persons apparently believe there is some other channel through which we gain information than our special senses. The idea is mere assumption. What appears to be a different source and a higher channel for acquiring knowledge is the result of the

process through which the mind puts the information gained through the special senses.

Deprive a neonatorum of the functioning of its organs of special sense and it will never give evidence of even the most rudimentary intelligence. Without the usually accepted special senses, this assumed *higher sense* never shows signs of existence. The functioning of this higher sense is a process of synthesis from which machines are made, books and poems are written, statues are carved, abstract problems evolved, and the highest thought and aspirations of the human race take voice. It is this ability to thus utilize the experiences that reach us—the Ego—through our special-sense avenues, by which we can hew out new lines of thought, cut channels which bear no traceable resemblance to the avenues through which the elements of our fundamental knowledge are received. We may give out knowledge, ideas which have passed through these channels within our individual domain of thought (the possession of which individual domain of thought makes each of us the centre of the universe), but we can receive nothing that does not enter our consciousness through one or more of our special senses.

It is fallacious to imagine that original work, either in science or in art, can best be done by bodies of men, by companies and syndicates. Military movements and commercial enterprises best succeed by the combined efforts of individuals; "in union is strength" is applicable to governments, and to all work that requires large amounts of force, weight or material quantity, or money; but in the work and developments of art and in the discoveries of science, quantity has no place. It is the single mind, with its keen, discriminating skill, its accurate training, its fine individualized technique that science and art demand. We need an accurate *materia medica*, but we should not expect it to come from the multitude, nor from the combined efforts of an organized body; it must be a work of art based upon the principles of science, and the interpretation of the ideal will come through the brains of individual workers, men of thought and of ideals, who are true to these ideals, and who cannot be moved by the plaudits of the multitude, nor intimidated by the raging of the nations.

It is a fallacy to consider every modern claimant to medical

fame as greater than Samuel Hahnemann. Hahnemann was one of the greatest speculative philosophers of his time, one of the most practical psychologists, one of the profoundest thinkers and the greatest physician. The results of his work will live for all time. In the near future may his grave have a fitting monument, and our profession's tribute to his memory soon rear its artistic head in our nation's Capital.

---

A CASE OF HEPATIC ABSCESS DUE TO AN APPENDICITIS; WITH ILLUSTRATIONS AND A SERIES OF MICROSCOPIC SLIDES.

BY CHARLES BECKER, M.D., PHILADELPHIA.

(Read before the Saturday Night Club of Microscopists, December 11, 1897.)

ABSCESS of the liver as a primary affection is rare in this climate, being almost invariably secondary to a septic inflammation in another part of the body, most frequently in the gastro-intestinal tract, infection taking place through the lymphatics and portal veins.

The case reported here is interesting, from the fact that the cause was apparently an appendicitis, induced by a pin, which was found post-mortem. The pin entered the appendix from the bowel, and perforated the appendix at its free end, making in this way a channel of infection from the bowel into the peritoneal cavity. Another curious feature of the case is that at no time did the patient exhibit any symptoms of having an appendicitis—that is, in having pain in the right iliac fossa, or at McBurney's point.

The history of the case is as follows:

Mrs. C., æt. 41 years, white, married, sent for me to see her on March 8, 1897. She complained of headache, backache and chilliness. These symptoms had existed for several days. She accounted for them by just having passed her menstrual period, at which time she was accustomed to suffer in this manner. While talking to her at my first visit, she was taken with a severe rigor, which lasted possibly an hour. This was followed by nausea and severe headache. Her temperature rose to 100° F., whereas it was normal before the chill.



On my visit the next day, the 9th, her condition was about the same. She had had no repetition of the chill. Her temperature in the morning was  $100^{\circ}$ , in the evening  $101^{\circ}$ . The physical examination at this time revealed all the organs to be normal except the spleen, which was enlarged.

For the next week her temperature gradually rose in the evening, with morning remissions. The bowels began to get loose, tongue dry and cracked, and slight delirium. At this time the case was thought to be one of typhoid fever in the second week of its course. Everything seemed to indicate this, except the non-appearance of the eruption. No stress was laid upon this, as it is well known in some cases the eruption is absent.

When seeing her on the evening of the 15th I was informed by the nurse that the patient had had a chill during the afternoon, and had been restless all day. On taking her temperature, the thermometer showed it to be  $105^{\circ}$ . She was delirious, and had considerable nausea; the latter symptom had returned after being absent for a week.

On the 16th her temperature in the morning was normal. A new symptom was the development of a painful spot about two inches below the ensiform cartilage, where there was great sensitiveness to pressure.

This sudden fall in the temperature, in combination with the chill the day before, made me suspect that I was in error in my diagnosis of typhoid fever, or that there was a complication. On examining her abdomen, I found that the liver, which had previously only reached the edge of the last rib, now extended to about one inch below the margin of the ribs.

On the 17th she had a chill at 5 P.M.; temperature in the morning,  $99^{\circ}$ ; evening,  $104^{\circ}$ ; liver dullness increased; had beating pain in the liver; nausea marked; bowels loose, brown in color and mixed with bile.

On the 18th temperature was normal all day. Liver dullness still increasing. Every other day thereafter she had a chill between 3 and 6 P.M.

A diagnosis of abscess of the liver was made from the enlarged condition of the liver, the character of the pain, and the irregular temperature. The case at this time was seen by Drs. A. M. Barnes and Theodore J. Gramm for their opinion as to

the diagnosis and a possibility of operating. They concurred in the diagnosis, but the patient's condition did not admit of much hope for an operation.

At our conference the question was considered whether the case might be one of intermittent fever. This was thought of on account of the regularity of the chills and the enlarged condition of the liver. Again, could it not be a case of mixed infection, that is, of typhoid and intermittent fever, similar to cases shown by Dr. J. M. DaCosta at the Pennsylvania Hospital Clinics last year, and reported in Vol. ii., page 98, of the *International Clinics for 1897*? But subsequent examinations proved that these suppositions could not be entertained, as will be shown later.

The liver dullness gradually increased until it extended down to the umbilicus and up to the nipple line. The patient finally succumbed to a general septicæmia on the 28th of March, or the twentieth day of her illness.

During the course of the disease the urine, blood and fæces were examined, with the following results: The urine was examined several times. It had specific gravity ranging from 1016 to 1024; albumin was constantly present, but in small quantities; sugar and bile were at no time present. The microscope revealed granular and hyaline casts, degenerated epithelium, and, late in the course of the disease, pus. The blood was examined for plasmodium-malariae, but this could not be detected.

The fæces were examined for the amœba colli and the bacillus of typhoid, but the examination proved to be negative.

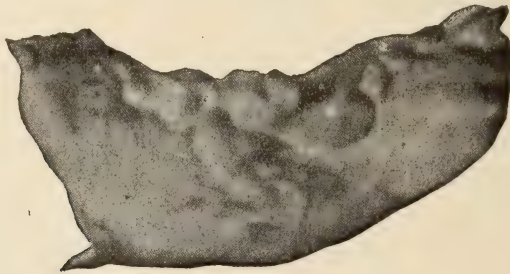
*Post-Mortem.*—Body emaciated, pale, sallow appearance, but not jaundiced; and here may be mentioned that at no time during the patient's illness was there any appearance of such. On opening the abdomen, the liver was seen to fill the entire right side down to the umbilicus. It was paler than normal in color. In trying to lift it out it was found to be adherent to the diaphragm, and in breaking up these adhesions an abscess cavity was opened, giving exit to about one litre of fetid yellow pus and gas. This cavity was formed by the whole upper lobe of the liver, and at no place was its wall over 3 c.m. in thickness. The upper surface of the abscess cavity was formed by capsule of the liver and the diaphragm, firm union having

taken place. On cutting into the other lobes, small foci of supuration were seen.

The spleen was enlarged; on section it showed no change, except being very hyperæmic.

The kidneys were enlarged, capsule free. On section they showed they had undergone advanced parenchymitis degeneration, and had several metastatic abscesses in them. This fact accounted for the pus found late in the urine.

The bowels were traced in the hope of finding ulceration, having in mind the original thought of typhoid fever, but no lesion could be found. In following along the bowel, we reached the appendix, which was adherent to the round ligament of the uterus on the right side, and from it a *pin* protruded. On removing the appendix it was found to be gangrenous at its point of attachment with the round ligament.



The pin measured about 3 c.m. in length, was corroded, its point protruded into the peritoneal cavity, as illustrated in the photograph.

The appendix was filled with pus, and the opening into the bowel was not occluded. The condition of the appendix, just described, seemed to solve the cause of the abscess in the liver, from a pathological point of view, viz., a subacute attack of appendicitis with ulceration and perforation, secondary infection into the liver from the portal circulation, and lymphatics.

The question arises here: Why were there no local manifestations of this lesion during life?

#### MICROSCOPIC EXAMINATION OF LIVER, SPLEEN, KIDNEYS AND APPENDIX.

In the liver there was a fatty and round-cell infiltration; small foci through the section showed beginning suppuration.



*Kidneys.*—Parenchymitis inflammation marked; slight interstitial changes; tubules filled with granular, epithelial and small hyaline casts.

*Appendix.*—Narrowing of the lumen; round-cell infiltration in the mucosa and submucosa.

The microscopic slides thus briefly described are herewith submitted for your inspection. I take pleasure in acknowledging the kindness of Dr. Theodore J. Gramm for allowing me the use of his laboratory for making the necessary examinations for this case.

The therapeutic treatment of the case consisted in the administration, at first, of gels., bry., rhus; later, arsenicum, hep. and lach. Before each chill quinine was given, but did not seem to have any effect, which is understood now since the cause is known.

---

### GENERAL PARESIS.

BY C. SPENCER KINNEY, M.D., MIDDLETOWN, N. Y.

First Assistant Physician Middletown State Homœopathic Hospital.

GENERAL paresis is a progressive degenerative brain disease that ultimately destroys the integrity of every tissue in the body. The mental symptoms may temporarily assume those of any form of insanity. The physical signs are those manifested in paralytic affections, the first of these symptoms generally showing in the speech. Apoplectiform attacks may occur at intervals, and death ultimately result from apoplexy or exhaustion.

We naturally dread the advent of general paresis in a friend, and would rather consider ourselves at fault in our diagnosis than to be too hasty in pronouncing his doom; for if he have paresis, doom it must be considered, as we know of no cure for the disease.

The material from which this disease claims its victims is the most active in the human hive. They represent the bread-winning portion of the community. Without the heredity that possesses the actual taint of insanity, they yet have a nervous predisposition that gives way when subjected to a

steady strain of worry and emotional excitement. The subjects for paresis are generally too ambitious for the amount of physical and nervous energy that they possess. They have qualities of mind that achieve success, so long as they are not hurried, and have sufficient time to recuperate from their efforts. When, however, an unexpected strain comes, or they doubt the outcome of an enterprise in which they may be engaged, then worry and sleeplessness get in their work, and paresis claims her own. By many, syphilis is believed to be one of the most frequent causes of general paresis. My experience has not confirmed this. Many paretics whom I have seen have had syphilis, but many more have not. In this, as in many other departments of statistical research, much depends on the locality in which the statistics are obtained.

In the earlier stage of this disease there is, as a rule, an element of depression running through the individual's mental moods. This may be pronounced or not, depending upon his ability to throw care aside. The growing inability to exert himself without unusual physical or mental fatigue, the lapses of memory, the painful consciousness of a weakened mental grasp upon subjects with which he has long been familiar, add to his depression, and give to him a nameless fear that may find occasional utterance to his immediate associates. His moods become variable, irritability is increased, the acuteness of his senses is lessened, there is frontal headache, vertigo, muscular tremor, and inco-ordination that is shown in attempting and failing to do manual work requiring precision that when in health was easy for him to accomplish. The pupils respond sluggishly to light, and are usually contracted, but may be dilated, unequal or irregular in their size. His speech may at times falter when under excitement, and he may stammer and stutter to an unusual extent. All these symptoms may present themselves before any marked mental change attracts the attention of his friends. There is, in my opinion, no one set of symptoms that can be considered as forerunners of paresis. They vary in time of occurrence with the degree of weakness of the part afflicted. With some it may be muscular inco-ordination, that manifests itself in action, walk, speech, or pupils, while in another the mental symptoms attract attention.

The change in the disposition is frequently attributed to something besides disease, and may show itself in an increase of irritability, restlessness, unreasonableness in everyday matters, a blunted moral perception that is at variance with previous conduct and thought, with a diminished appreciation of family ties, an increase of sexual desire, carelessness of person, and impaired memory, reason and judgment. He is inconsistent, as shown in actions, purchases and plans; the common rights of property are ignored, and self, blind, demented, restless and reckless, becomes involved in all his deeds. As the disease progresses the physical and mental symptoms become more pronounced, until the character of the disease is first fully recognized after the patient has committed some overt act that attracts attention to his mental state. When this has taken place, the relatives and friends of the patient willingly assist in furnishing data of the first changes they noticed in his method of acting, living and speaking, and of the complaints of ill-feeling that at rare intervals the patient had uttered. In this way alone is it possible to obtain a fairly complete history of the manner in which the disease began and progressed.

The duration and characteristics of the prodromal stage varies with the degree of inherited resistance. In some instances the time is found to extend six months or less, while in many cases a year or two embrace only the first stage. Perhaps more importance should be attached to a mental symptom that is one of the earliest and most frequently found in this disease,—the indifference to the ties of kindred and to the everyday responsibilities of life. When this condition is discovered it should emphasize the importance of all other existing mental and all motor symptoms, for paresis can only be diagnosed correctly by taking the mental and motor symptoms together. This mental condition of indifference is also a forerunner of irresponsibility. The exalted ideas, about which much has been said by writers on this subject, may be wanting, but when present develop very rapidly. A suggestion of the most outrageous and visionary scheme is seized by the parietic, and, in his fancy, substantial results at once materialize for his personal advantage. Power without limit is claimed by him, and so devoid of reason is he, that at this period he perceives no inconsistency in planning to use untold wealth, when perhaps he



has not the means to purchase a common two-cent postage stamp. Free expression is given to beliefs and plans that wholly lack the restraint of experience and judgment. No matter what argument is brought to bear on him to show the absurdity of his position, to explain to him the interminable space existing between his projected future and his wretched present, a wave of a tremulous hand, a stuttered exclamation of derision, and a wobbly smile passing hastily over a demented face, in which the emotions of apprehension and contentment seem to be struggling for the mastery, will be the only answer. There is no forceful continuity of intelligent purpose left in him; a desire to do anything or to go anywhere can be quickly changed by a tactful suggestion. Muscular tremulousness increases, the reflexes are increased at first, and later on they are lost, ataxic features become marked in his walk, although he does not fall on closing his eyes, as in locomotor ataxia. Rheumatoid and neuralgic pains are felt at intervals, but they are seldom constant. Speech is broken, and efforts to repeat such phrases as "around the rugged rock the ragged rascal ran" and "truly rural" terminate in complete failure. Judgment, education and training no longer control his appetite, as he will frequently eat until his stomach rebels. Taste is impaired, as shown by the amount and character of the food he is inclined to eat. Acts of indecency are committed with no appreciation of their impropriety. Carelessness of dress is added to the other symptoms, as if the amenities of life were too trivial to engross the time of one who has so much to accomplish.

Apoplectiform attacks are liable to occur at any time, showing themselves in added difficulty of speaking in some other form of retarded muscular action, or in an unusual dullness of mental perception, accompanied by contracted and fixed pupil. The effusion may extend to a complete and fatal apoplexy. Constipation or retention of the urine, either one or both, will induce these seizures. Cutaneous anæsthesia is complete in some cases.

A feature of the disease that is liable to develop at any stage is the remission of both physical and mental symptoms. These should not be considered lucid intervals, as it is very doubtful if such intervals ever occur in a case of general paresis. They

vary in length, from a few hours to several years, and illustrate how vigorously nature endeavors to re-establish a healthy equilibrium whenever she has the slightest opportunity. Why these remissions take place is not known; their advent cannot be foretold, nor their duration presumed upon; they may be partial or complete in their character, and may enable the patient to resume the ordinary cares of self-support with much credit to himself and with justice to those depending upon him. Under excitement, increased and unnatural tremor may be observed. The affective sentiments remain diminished, but are reasonably influenced by relationship. The return of the active symptoms may take place without warning, and progress until death closes the account.

We have not attempted to divide the disease into stages, as they are not distinct, and are purely arbitrary. The last condition is difficult to describe. We have all seen the emaciation of phthisis, the helplessness of the paralytic, and the dementia of old age. Combine, if you will, the unfortunate characteristics of them all, and you have a suggestion of the end of a case of paresis, when apoplexy does not cut short the course of the disease. In many cases, when every other organ of the body seems worn out, and when no physical or mental characteristic remains of the man that is not a ghastly burlesque of his former self, his heart yet beats steadily on and his vegetative existence is prolonged.

In several cases seen by me in their beginning, throughout their course and at the end, the attack began with melancholia, and the patients made what seemed an excellent recovery, giving no hint that paresis would follow.

Ataxia, chronic alcoholism, epilepsy, paralytic affections, chronic mania and mania of the senile, may at times present symptoms suggestive of general paresis, but in none of these diseases do the physical and mental symptoms unite to form a perfect picture of paresis, and without such combination of symptoms no diagnosis of paresis should ever be made.

In the treatment we are to bear in mind that the whole tendency of the disease is toward a disintegration of every tissue in the body, and that the blood of a paretic is poor in quality and deficient in amount; consequently the efforts of the physician should be directed toward correcting these deficiencies.

In diet, that which is easily digested and is nutritious has the first claim. That annoying personal equation confronts us which pronounces the food of one man meat, while with another it pronounces the same food poison. From the following list the food of paretics may be selected:

*Soups.*—Mutton, beef, chicken, clam, oyster, and thick soups.

*Fish.*—Codfish, mackerel, haddock, bass, clams and oysters.

*Meats.*—Beef, roasted, chopped or scraped; mutton, chicken, game, eggs.

*Fats.*—Butter, salad oil.

*Bread.*—Whole wheat, rye, or rye and Indian, corn-bread, toast.

*Vegetables and Fruits.*—Cresses, celery, lettuce, peas, asparagus, spinach, apples, oranges, grapes, and dried fruit thoroughly cooked. Baked apples are with many a decided relish.

*Drink.*—Pure spring water, apollinaris, or clysmic. Sterilized milk, freely taken, hot when possible, is the most important of all drinks, combining, as it does, the best qualities of all foods. Tea may be taken freely, Ceylon preferred. Coffee, if taken at all, should be without cream. Sugar may be used if desired.

There is no special kind of nursing that is applicable alone to a case of general paresis. Any treatment that is sustaining is to be considered. Great care must be taken that the patient does not exert himself too much, either physically or mentally. Physically, he is incapable of making any long-continued muscular effort without danger of bringing on apoplexy, especially when the disease has become thoroughly established. Mental excitement in any form is also prejudicial. Being easily diverted from his schemes, it is easier to guard a paretic from attacks of excitement than patients who suffer from mania, or from profound depression accompanying melancholia. However, should such attacks occur, the same degree of care must be given as in any similar condition. The patient should rest in bed from five to ten days, and no physical exertion or mental excitement should be allowed after an apoplectiform seizure. The free use of sterilized water enemas, to prevent constipation and its consequent auto-intoxication, should be freely employed whenever necessary. The bladder should be irrigated



whenever the urine is cloudy or filled with sediment, or ammoniacal in its character. The stomach should be irrigated when the patient suffers from catarrh or from an acid condition, which induces fermentation annoying to the patient, and in some instances causing him to refuse food.

The drug that has given the most satisfaction in the treatment of apoplectiform seizures is opium tincture, using ten drops in half a glass of water, and giving a teaspoonful every half-hour or hour, as the occasion demands. Aconite, first, affords relief when the convulsions assume the status epilepticus. Arnica has been used with benefit when the patient is recovering from the attacks. Arsenicum is especially indicated during the stage of emaciation. For the periods of exaltation, belladonna, hyoseyamus, platina and stramonium have been used, perhaps, more frequently than others, although the character of the delusions and the condition of the patient render it impossible to give a satisfactory list of drugs called for during the course of the disease.

Twenty years ago it was the practice in this hospital to keep the cases of general paresis up and dressed as long as possible, believing that by so doing we added to their comfort, prevented bed-sores, and prolonged their lives. After several years' trial and observation we became convinced that this method of procedure was unjust to the patients' interests, as it did not enable them to receive the degree of medical care and the attention of trained nurses that was theirs by right while in a hospital. During the past seventeen years improvements in the care of these patients have been made along the lines of the "Hospital Idea," as described in 1890 by Dr. Selden H. Talcott, the keynote of which, in practice, is a close individualization of the patients' needs.

Electricity has not been of service in the treatment of general paresis, and its use is contraindicated.

It is impossible to say that any one variety of bath is superior to another, for where one patient may be benefited by a spray-bath, another fails to receive benefit, but does well with an alcohol bath. A wet-sheet pack, when the patient is strong and excited and suffers from insomnia, is of marked advantage in many cases. But whatever form of bath is employed, unless reaction follows, it should not be repeated. It is necessary to

keep the pores of the skin free and clear, in order to promote as much elimination as possible, but the character of the bath should depend upon the strength of the patient, and here a close individualization is necessary.

The pathology of general paresis is more marked in the appearance of the brain than that of any other form of insanity. Dr. Powelson has kindly furnished me the following report of a post-mortem examination made during the past month:

CASE No. 4370.—Admitted March 22, 1895. Died January 12, 1898. Male; white; age 42; single; no history of heredity; history of syphilis and masturbation of long standing.

The integument of the head was slightly thickened. Occipito-frontalis muscle well developed. Small bony excrescences were observed here and there over the entire surface of the brain. The tables were greatly thickened throughout their entirety, being especially well marked in the parietal and occipital regions, where they measured one-half inch in thickness. The pia mater was found to be very vascular, and adherent in spots to the cortex over the frontal and parietal lobes, and when torn away left an abraded surface. The dura mater was the seat of a general ecchymoses, particularly noticeable in the parietal region, where it extended through the membrane, staining the pacchionian depression. The brain itself was considerably atrophied, and, notwithstanding its general oedematous condition, weighed but thirty-seven ounces. The serous infiltration was universally distributed, being most pronounced in the middle lobes, where the lateral ventricles were found distended with the fluid, and this amounted to ten ounces. The choroid plexes were clearly marked, and appeared to be in a state of passive congestion. At different places throughout the brain-substance portions of disorganized and broken-down tissue were observed. No further examination made.

Statistics in reference to paresis are misleading, owing to the fact that cases of senile dementia in the excited stage have been classed as paresis. While general paresis rarely shows itself before twenty years of age, it is extremely rare at sixty, and very unlikely to occur after sixty-five. The following table will show the number of cases of general paresis reported by eleven State hospitals from October 1, 1888, to September 30, 1896.

	Men.	Women.	Total.
Whole number insane admitted during the period,	20,588	18,781	39,369
Number discharged recovered, . . . . .	3,550	3,443	6,993
Number discharged dead, . . . . .	6,210	5,541	11,751
Died from general paresis, . . . . .	1,620	266	1,886
Percentage of deaths from general paresis, based on whole number of deaths, . . . . .	13.79	2.25	16.03
Whole number of insane in the eleven hospitals, September 30, 1896, . . . . .	9,685	10,352	20,037
Percentage of deaths from general paresis, based on whole number of insane resident, . . . . .	8.08	1.33	9.41

No. 4345 was admitted to the Middletown State Homœopathic Hospital March 6, 1895. He was 47 years of age; married; nativity, England; came of a family of three children, all now living; father died at fifty-five years of age from brain fever induced by worry; mother died from cholera when patient was a year old; maternal uncle insane; brother intemperate; the patient resembled his mother physically; twice married; had one child by his first wife, that died of convulsions when nine months of age; patient healthy when young; in early life no injuries; was a good student up to fifteen years of age, when he went into an office as clerk; at twenty years of age emigrated to the United States; he became a commercial traveller for the next seven years of his life, and then went into business for himself, and continued therein up to his last sickness. During the previous two years his business ventures proved unsuccessful, owing to the failure of several firms with whom he had large contracts. The fulfilment of these contracts placed him at considerable expense, and being unable to collect money that was due him he was caused a great deal of anxiety and worry. There is no history of excesses or of any specific disease. The patient was married at the age of twenty-nine to his first wife, who lived ten years. She is said to have been a talented, brilliant and beautiful woman, who had been on the stage, and he was devoted to her. Soon after marriage she developed a fondness for morphine that she was unable to give up till death, which resulted from cardiac embolism. His wife's death affected him greatly, and for several months melancholy was averted only through the kindness and care of his friends. Five years later he married again, a woman older than himself. During the previous ten years he had dyspepsia for a week, also a few colds, and some difficulty with his kid-



neys, the character of the latter trouble being unknown. He lived extremely well; had choice wines for dinner daily, but never drank to excess. For over a year previous to the outbreak of the attack his moods were variable, and changed without cause; complained of headache; was irritable to a marked degree; cross in speech; unreasonable about everything. Previously he had been courteous in manner and elevated in moral tone. He became careless about his clothing, about which he had previously been markedly fastidious. This state of affairs continued for a year with no thought that his condition was serious until nine weeks ago. After attending a ball he began vomiting, and was unable to retain his food for the next week or two. Physicians were called, and his case was diagnosed locomotor ataxia. He was then sent to a private institution, where he remained until he came here. Physically he appeared strong, especially during excitement, but was easily fatigued.

On admission to the hospital the patient weighed 155 pounds; height, 5 feet 11 inches; losing flesh; somewhat anæmic; temperature 99; pulse 72, regular but small; respiration 20; tongue tremulous, coated dirty white at base; pupils dilated and sluggish; patella reflexes lessened; slightly ataxic; did not perspire freely; skin dry; drank more water than usual; was constipated; urine, color yellowish; reaction, acid; specific gravity, 1023; phosphates increased; heart, lungs and abdominal organs healthy; stomach dilated with gases; slept poorly for some weeks; was then sleeping well; talked seriously only in answering direct questions; memory good; mood exalted; mental state imaginative, unreasonable, unstable, illogical, and he possessed the most implicit credulity in all his mental impressions; could not talk long on one subject; easily confused; affections lessened; had delusions and hallucinations; delusions were unsystematized, and his entrance to the hospital apparently suggested the following scheme:

He and a wealthy patient would form a stock company with shares of one million dollars each, for the purpose of establishing a club, the initiation fee to be fifteen hundred dollars, but a few friends to be admitted for two hundred and fifty dollars; all the crowned heads to be invited to join, but the fee would be raised for them. After a year the stock would be put on the

market. The club would purchase ten thousand acres of land up in Maine or Canada, have all the flowers of California, and if the weather became too cold the entire park would be enclosed in glass. In this park he would have duplicates of all the famous cathedrals of Europe, the originals of the monuments, but none of the bones; simply the bones of well-known Americans. All the palaces and famous paintings would also be in the park; intended to buy a railroad, and engines would then run about one hundred and fifty miles an hour. A line of steamers would be purchased, and would make the trip from New York to Queenstown in twenty-five and one-half hours. Aluminum ships would be stationed along the route, to be used for health resorts. (Bell. 200, 3 hrs.)

On the 11th, belligerent; wants to fight. 17th. Keeps up the most exalted delusions along the lines previously mentioned; no limit to the amount of money he is able to control; tremulousness is increasing; face growing pale, and has a strained expression; sleeping poorly; sphincters relaxed; appears to be losing courage and faith in himself and his schemes; is inclined to be irrational; insists that the doctor must pay him one million dollars a minute for the time that he is detained in the hospital, and sends to the doctor a statement of his indebtedness to him in a tremulous, broken, disconnected scrawl, acquainting the doctor with the fact that the amount he already owes takes up seventeen decimal places.

April 1st. Weight, 146 pounds; continues to talk of his delusions; writes less, and is more feeble. 17th. Is in a dazed condition; washes himself over and over again, forgetting, apparently, that he has washed but a few moments before; at times does not know where he is, or whether it is morning or evening; cannot remember whether he has eaten anything or not; throwing things out of the window without cause; disturbing the furniture and keeping his room in confusion. On the 19th believes that he is being poisoned; demands his clothing; thinks that he is going to have visitors; memory poor; mutters to himself; wants to bathe frequently; refuses to eat; at times appears to have hallucinations of sight and of hearing; believes that he has telegrams from God and from Queen Victoria. This delusion he mentioned for a number of days. May 1st. Weight, 125; sexually excited; says that he

can kill a million of men in a minute, and that he can breathe into them the breath of life; talks of having seen the throne of God, and attempts to describe it, saying that it is made of gold studded with diamonds. 14th. Says he went to Canada last night, and that he caught a trout weighing ninety-two thousand pounds, which was filled with rubies. 21st. Was very noisy in the forepart of the night. 23d. Noisy and restless during the night; hallucinations of sight and hearing; talks in a deep voice, with no tremor of tongue or mouth, of his plans for the future; angry and fault-finding if not allowed to do as he wishes; profane and vindictive in his speech; appetite is good. 28th. Is quiet, and acting with very good self-control. June 1st. Weight, 127 pounds; no especial change. July 1st. Weight, 124 pounds; is now sleeping from five to seven hours nightly; talking in a quiet manner of what he proposes to do; delusions as grand as ever; indifferent to everything about him; voice beginning to fail; breaks in speaking more frequently than he did. 10th. Heart and pulse feeble; walk tottering; weight, 122; temperature,  $97\frac{2}{10}$ ; pulse, 62; respiration, 16. 11th. Feeling better; appears stronger. August 1st. Weight, 124 pounds; no especial symptoms since last entry; continues to have hallucinations of sight; gesticulating violently, but with grace of action and method (was at one time a student of elocution); says that he is doing it for exercise; face pale and drawn; expression anxious. September 1st. Weight, 131 pounds; no especial change. October 1st. Weight, 142 pounds; very pleasant in his manner, and more careful of his person; contented, although apparently having the same exalted delusions and hallucinations of hearing; waves his hands suddenly about in the air without apparent cause; seldom speaks unless addressed, when he answers intelligently. November. Weight, 132 pounds; no especial change. January 1, 1896. Weight, 142 pounds; continues to sleep from five to seven hours daily; quiet and gentlemanly in his manner. February 1st. Weight, 146 pounds. He did not change in weight or mental condition until March, when he began gradually to fail, and from that time on his condition required the constant attention of nurses during the day, and occasionally during the night, although, as a rule, his sleep was very fair. His strength failed rapidly toward the last of his illness, and he became very much emaciated, and died May 11, 1896, from exhaustion.



## URÆMIA AND ITS TREATMENT.

BY E. G. COWPERTHWAIT, M.D., PHILADELPHIA.

(Read before the Trousseau Clinical Club.)

THE principal function of the kidneys is to remove from the body excrementitious substances.

It is well known that certain diseases of the kidneys interfere with this function, and that the waste material accumulates in the blood, giving rise to a group of symptoms which lead one to believe that the patient is suffering from a form of toxæmia. To these morbid phenomena, which affect particularly the nervous centres, the name uræmia has been given. In spite of the implication of its name, the pathology of uræmia is still a disputed point.

The theory of its being due to the presence of urea in the blood is maintained by many, notwithstanding that in many instances large amounts of urea may be present in the blood without causing uræmic symptoms. Frerichs believes that the urea itself is not injurious, but that it is converted into carbonate of ammonium through the action of a peculiarly organized ferment. Recently it has been suggested that the uræmic symptoms are due to a poison in the blood, but that this poison is not due to any disturbance of the function of the kidney.

The symptoms of uræmia may appear in an acute or chronic form. Of the acute symptoms, convulsions and coma are the most prominent. The convulsions are epileptiform in type, and may be mistaken for epileptic seizures. The onset is sudden, and the seizures may follow each other closely, or may be several hours apart. Coma, as a rule, exists during the intervals between the seizures. Coma may appear as a primary symptom without convulsions.

In chronic cases the convulsions are often preceded by headaches, vertigo, disturbances of vision and hearing, gastrointestinal troubles and mental disorders. The uræmic attack is often precipitated by some form of digestive trouble. In some instances I have known the symptoms to closely follow an attack of indigestion.

It is to the treatment of uræmia that I wish to direct your special attention. In the first place, it is of the utmost importance to ascertain as accurately as possible the meaning of the vague and oftentimes seemingly trivial symptoms which often occur in patients under our care.

In those patients who come to us complaining of headaches, vertigo, failing vision, gastro-intestinal troubles and sleeplessness, a careful examination of the urine should invariably be made. This is a proceeding which is oftentimes sadly neglected, a kidney-lesion not being suspected until a convulsion takes place. The examination should be microscopical as well as chemical, chemical tests alone being inconclusive, as they often reveal nothing when a grave kidney-lesion is present.

When uræmic symptoms develop during the course of either an acute or chronic nephritis, particular attention should at once be given to the diet, the condition of the skin and bowels. Animal food should be prohibited, some form of farinaceous food being used in its place. Rest must be commanded, in order to prevent the production of nitrogenous waste-matter by the muscles. As the urine is scanty the activity of the skin and bowels should be increased, in order to relieve the damaged kidneys as much as possible. Hot baths and the hot-air bath may be employed for their sudorific effect. The bowels should be freely opened by a saline purge (a ʒ or so of the sulphate of magnesia); or, when a quicker action is desired, croton oil gtt.ii in ʒi of olive oil may be given. Water (preferably distilled) should be given freely from the first, as it tends to dilute the poison, thus rendering it less toxic. As to drugs, those that promote elimination from the skin, kidneys and bowels must, in the main, be relied upon. Of the drugs which increase the urinary flow, digitalis is the one most generally employed. It is best given in the form of the infusion, or it may be used in combination with strophanthus and nitroglycerin. Another drug which is sometimes very efficacious is theobromine, given in from five- to eight-grain doses in capsules; it often increases the flow of urine to a marked degree. Pilocarpine has been used hypodermically for its action upon the skin. It is contraindicated when the heart's action is feeble.

For uræmic headache, with high arterial tension, glonoin is a valuable remedy. In regard to the arsenite of copper, Goodhue

has strongly advocated its use in uræmia. I have had some little experience with it during the past year. In one case which I recall it seemed to exert a marked influence, lessening the convulsions and increasing the flow of urine.

The chloride of gold is a remedy that may be useful, especially in chronic interstitial nephritis, when the urine is pale and copious and the urea is diminished. In severe cases it may be necessary to attempt to control the convulsions by chloral and bromide of potash.

In conclusion, I would again emphasize the importance of making careful urinary examinations in all doubtful cases. I am fully convinced that kidney affections are much more prevalent than they are supposed to be, and that many deaths that are credited to other causes are in reality due to some lesion of the kidneys.

---

#### BEER AND THE BICYCLE.

BY CLIFFORD MITCHELL, M.D., CHICAGO.

WHAT is the best beverage for bicycle riders? If this question were submitted to a large number of cyclists, the writer believes the verdict would be in favor of beer. The writer is, however, greatly opposed to beer as a bicycle beverage—not from the teetotalist's standpoint, but on general principles. Inasmuch as bicycle-riding accelerates the pulse, why drink any alcoholic beverage at all, except, perhaps, some little time after a long ride is over, when the person is trying to rally from fatigue?

Next, what is the result of bicycle-riding on the urine? That of any fatigue and profuse sweating, namely, a tendency to concentration. Appetite and thirst being greatly stimulated by exercise in the fresh air, the cyclist eats heartily of animal food and drinks freely of beer. Now it is a well-known fact that the free use of animal food and malt liquor, coincidently with excessive fatigue and profuse sweating, is likely to cause a concentrated quality of urine, in which crystallization is likely to take place, and that it is not improbable that in a coincidence of favorable conditions of this kind many cases of



stone have their origin. The writer has been led to a consideration of this matter after seeing repeated attacks of renal colic in a cyclist, with history of renal calculus prior to bicycling. This cyclist is an enormous eater of meat, and uses beer freely as a beverage during his centuries.

Without desiring to pose as an alarmist, the writer, nevertheless, thinks it proper to warn those of gouty habit to eschew beer altogether when bicycling, and, instead, to drink freely of spring-water. Farmers and others on whose premises good springs are found would do well to advertise the fact, and sell various articles of food to the cyclists, who, in time, would congregate about the springs. At Western Springs, on the Aurora-Elgin century course, the writer has counted hundreds of cyclists in a day who dismount to drink of the refreshing spring-water; but thus far no one in the vicinity has been sufficiently enterprising to pitch even a tent where lunch might be had.

In order to overcome the tendency to concentration of the urine and resulting crystallization of solids, free ingestion of liquids is a necessity. The best liquid for this purpose is water, and the best water a pure spring-water. The writer thinks that the day will come when the rank and file of bicyclists who take long journeys will appreciate this, and that property on which good spring-water is to be had will be of value for inn-keeping purposes.

---

#### THE MEDICAL TREATMENT OF SEXUAL PASSIONS.

BY JOHANNES ARSCHAGOUNI, M.D., NEW YORK CITY.

(Read before the Homœopathic County Medical Society, N. Y. C., February 10, 1898.)

PHILOSOPHY teaches us that a human being is a natural compound of a body and a soul, and, consequently, in man all actions are compound, all passions are compound. Hence, no action or passion belongs separately either to the body or to the soul, but to the individual as a whole, that is, to the *living compound* of a body and of a soul. Medicine, from its early origin up to recent date, has studied carefully the corporal or somatic ailments in the human frame, directing all its attention

to the material being, entirely overlooking the psychical ailments, and neglecting the moral and intellectual being. To Hahnemann honor is due for his early recognition of this dual existence in the human being. He is certainly clear in his *Organon* in this matter, and his provings of drugs confirm his belief, as from the first drug, *china*, down to *zincum*, proven by the master, psychical symptoms, classified under the *mind* specially, are scrupulously observed and noted.

We now live in an epoch where the healing art recognizes corporal as well as psychical morbid affections, called passions; and the success already attained in many homœopathic asylums and sanitariums, in the treatment of mental and of psychical diseases, is strong evidence of the truth, and a credit to the advancement of the healing art. The existence of these institutions greatly simplifies my purpose, and, inspired as I am by the little book recently published by Dr. Gallavardin, of Lyons, France, entitled *The Medical Treatment of Sexual Passions*, I shall try to call your attention to this most important subject, for it opens a new field of labor to the members of this new school of medicine. Eminent medico-legists, particularly Casper, Ternowsky, Tardieu, Brouardel, Westphal, Krafft-Ebing, Moll and others, have described pretty accurately various psychical morbid conditions, classified as sexual passions, which are but various forms of satisfaction of the sexual instinct. The subject is a delicate one for this audience, and I shall not enter into its particulars. Those who have read the works of the above authors will understand me, and those who have not must study them as physicians. Sexual passions are manifold, and, considering that sexual desire is not for the individual carnal satisfaction, but designed to propagation of the species, any tendency outside of this aim is by the fact considered as pathological, just the same as are the cravings, for instance, for chalk, charcoal, rags, or craving for one peculiar thing and aversion for others. We consider this a morbid appetite, because the substances craved for and eaten are not foods.

In the list of sexual passions we find classified: Premature sexual instinct in both sexes; self-abuse in both sexes; prostitution in both sexes; homo-sexual tendencies early and late, or sexual perversions, the so-called Uranism, a term first adapted

by Ulrichs; psychical or psycho-sexual tendencies, that is, a man whose sexual desire is not stable; he may have a tendency for both sexes now and then. These sexual perversions have various manifestations, which I shall not specify. There are, however, some varieties which could be mentioned, such as Fetichism, Masochism and Sadism. Fetichism is a condition in which the individual is greatly excited sexually, and his sexual desire satisfied, without any other action, at the sight of a certain portion of the body of the female, or of an object belonging to her only; for instance, one will feel excited at the sight of the foot of a lady with shoes or stockings on; a bare foot will have no effect whatever. Again, will get excited at the sight of a bare hand, while when with gloves on it will have no effect.

*Fetichism for objects* are numerous. It is a somewhat sensual idolatry for the possession or simply for the mental representation of one part or the other, or object of toilet; for instance, the boots, handkerchief, the hair of the loved one, etc. This exists in both sexes. This passion often was not understood, and the party who appropriated the object was taken for a thief, and he would probably be so considered to-day. Some of them will rejoice sexually by tearing with their teeth the handkerchief of the loved one. Others will get excited with desire when the opposite party will be dressed in a certain manner, or have certain things on; for instance, patent-leather shoes and black stockings. These are *sine qua non* conditions for their sexual excitement and satisfaction.

*Masochism*, a term adopted from the name of the renowned novelist, *von Sacher Masoch*. This morbid phenomenon consists in a passive submission and in a desire of being beaten and harshly treated by the loved one; for instance, it is reported that J. J. Rousseau could only feel a sexual excitement when beaten by the woman he loved. There are women who are absolute mistresses of their husbands; the man is simply a slave, owing to this condition.

*Sadism* is just the opposite condition. Sexual excitement and satisfaction is possible only by beating, harsh treating and humiliating the person whom they love. The term is taken from the name of the Marquis of Sade, the famous novelist, who was condemned to the death-penalty for immoral conduct. He



wrote in his cell novels, where he established the existence of a close relation between sensuality and cruelty.

There are also relations between sensuality and pain; and many known authors, amongst them Blümroder, Krafft-Ebing and Lombroso, have maintained that what for one would cause a pain will be a joy for another. Numerous cases are on record showing that pain inflicted on his victim will excite intense sensuality in one who is causing this pain, and only then, and at no other time. Murders committed in the manner of Jack the Ripper are a good illustration of Sadism. All his victims were disreputable women, and certainly no sexual excitement could have arisen in him unless he killed his victims in a peculiar style, as we well know. A mild form of Sadism is of frequent occurrence in ordinary married life, when the husband takes pleasure in teasing and scoffingly criticizing his wife, or *vice versa*.

Rape often committed on young girls has been classified as Sadism. Krafft-Ebing reports the very interesting case of a man who felt only once a voluptuous sensation, and this when he criminally assaulted a young girl. The same girl, after that, could not excite his sexual passions. This man will surely hunt such occasions to satisfy his animal passion. This may explain some of the cases of marriage where one felt very much attracted towards the other, yet, after the first day of married life, have had a disgust for ever. Like the Marquis of Sade, Gilles de Laval, the French marshal, used to assault young boys, torture and kill them. He paid for his crimes in 1440, being burned at the stake. History is full of such terrible events. There have been tyrants, and there are even those to-day who would enjoy a peculiar voluptuous sensation and feel an intense sexual desire only when witnessing\* the convulsions and the blood of sheep, chickens and geese killed for the purpose right before their eyes. Tardieu mentions many criminal assaults and rapes committed by both sexes, and criminal assaults of females upon their own sex, and some upon their own children.

*Necrophilia* is another brutal passion. Michea, in 1849, reported the case of a Sergeant Bertrand, who at times used to kiss corpses, caress, and assault them; at other times he used to cut the corpse into pieces, and feel sexually excited, and perform the act of self-abuse. This Bertrand had no choice;

both sexes were equally good for him. Psycho-sexual hermaphrodites generally married have periodical attacks, and at times express a coldness towards their wives. Such paroxysms often cause trouble in married life, and divorce follows.

*Ætiology.*—An eminent criminalist, who has made serious studies of such questions, admits that sexual perversions begin even from infancy, and it is simply congenital predispositions, like in any other disease condition. Heredity, then, is at the bottom of these neuro- or psychopathic disturbances. Other contributing causes are considered to be: Alcoholism in the parents, consanguineous marriages, and a great difference of age between father and mother; moral contagion, bad examples, habits, climate, food, epilepsy and senile dementia, diseases of the cerebellum and of the cord. Many reflex irritations are also considered by many as potent factors. Chevalier admits sexual perversions as symptoms at the onset of general paralysis. The so-called refinements of civilization often affect morbidly the human nature.

Diagnosis is difficult, of course, for those who are affected with any of these morbid sexual tendencies seldom confess. Dr. Moll says that many think there is no cure for their condition and therefore do not apply for advice, and to tell the truth we are not much prepared for them, for we know so little about these psychopathies; on the other hand, one who has carefully and intelligently read the subject can often detect it. Tardieu and others admit that there is something in the face, gait, manners and conversation, etc. The physician must know how to approach such a patient and dissipate his shame, telling him that such phenomena are diseased conditions to be met with in many, and that there is a cure.

*Treatment.*—Casper, one of the earliest authorities in the matter, says with right that the sexual life whose secrets are unveiled with certain shame in its aberrations belongs to medicine; but old-school authorities, while so cleverly and minutely describing these psychopathies, are, like in other mental diseases, powerless and at loss in their treatment and cannot see their way, and declare, as does Dr. Moll, that inclinations and sensations cannot be abated by hydrochloric acid or aloes, and they rely entirely on psychical measures.

Col. Ingersoll says, "You can prevent a man from commit-

ting a crime, but you cannot prevent him from wanting to commit it." Homœopathy, however, says the contrary, and can prevent him even from wanting to commit the crime, and thus ameliorate his character and develop his intelligence. Religion, education, instruction, medicine, food and climate, all have indeed to be used; hence prophylaxis, like in any other disease, should also be applied in these affections. Hydrotherapy, mental and manual work, outdoor exercise, surroundings, nutritious and non-exciting food, psychical influences, suggestions, all have their beneficial effect.

Suggestion is said to have in some cases proved successful, and cases are reported by Kraft-Ebing, Schreck-Notzing, Ladame and Moll. The latter has a strong tendency in the belief of hypnotism, claiming to have cured cases, provided a deep hypnotic sleep is produced. But above all, the principles of homœopathy applied to these affections will constitute an important curative factor.

Dr. Bourgeois, a French homœopath, wrote thirty years ago an excellent book on passions and their relations to health and disease, especially on love and libertinism, and devised their homœopathic treatment with record of many cases cured. The remedies mentioned in his work, with their indications, are aconite, belladonna, cham., puls., nux vom., phos. acid, china, ferrum, ignatia, hyos., hellebor., sulphur, merc., iodium, silicia, ars.; all of these he declares are the best remedies, when indicated, to correct the morbid passions, be they congenital or acquired. In treating Libertinism and all its consequences, such as onanism, uranism, homosexual tendencies, as described by Krafft-Ebing in his *Psychopathia Sexualis* and by Moll in his *Perversions of the Sexual Instinct*, Dr. Bourgeois mentions sulph. calc. carb. for onanism, and for its sequelæ china, ferrum, and phos acid; for excessive sexual appetite, phos., canth., carbo veg., china.

Dr. Gallavardin is the best authority, however, who has made special studies in general psychopathies in his Polyclinic Dispensary, at Lyon, for more than twenty years, and already, in 1882, he showed in his other work "how the homœopathic treatment may better the character and develop the human intelligence," the cures of antipathy, jealousy, brutality, greediness, gambling, laziness, and other vices and passions. His



little new work contains a variety of cases of sexual passions cured by him with homœopathic medicines. As a good homœopath, he declares, however, that when he has to treat a case of this nature he always selects a remedy which will cover both the somatic and psychical symptoms. I shall omit mentioning his illustrative cases, and I shall only give the medicines he employs for the various psychical ailments. For instance, incontinency: Alumina, causticum and conium are well indicated. In lubricity of imagination, a most difficult symptom to abate, and found in senile dementia: Conium, china, platina, nux vom., lyc. In sensual lubricity: Causticum, phos., canth., bell., plat., verat., stram. For those who are after little girls: Plat., verat., phos., caust. For Onanism: Origanum majorana, china, puls., nux v., sulphur, coffea, staph. and causticum. For unusual habits between married couple: Caust., plat. In homosexuality in both sexes: Calc. carb., plat. For Uranists: Platina. For those who have no bashfulness: Hyos., bell. and phos. For corporal antipathy caused by the individual temperament, which often exists between two persons: Calc. carb., ammon. mur., nitric acid, caustic., aurum, croctalus. For those who attempt sexual intercourse only when they are intoxicated, thus causing many disturbances to their wives, insomnia, and uterine disorders, with chance of procreating vicious, idiotic children: Con., calc. carb., nux vom., caust.

Dr. Gallavardin goes still further, and claims to cure adultery with staph., puls., plat., verat., lach., caustic., phos., and records cases in evidence. He also records cases of Sadism cured by caustic. 200 and and staphis. 200. He mentions the case of a man who used to ill-treat, beat and expel his wife, seeking divorce, who, under caustic. 200 and staph. 200, changed entirely. He also mentions cases of bachelors who, under staph., verat., plat., phos., lach., have abandoned their mistresses and got legitimately married, and claims that nux vom., lach., staph. are efficacious in creating not a passion but a taste for married life. In this occasion he mentions our lamented Constantin Hering, who used to give lach. in cases of young people who for no reason were undecided to be married, and lach. seems to have had the desired effect. Several weeks and months are necessary to succeed, he says, and yet at times one single dose may be found sufficient. For instance, one single dose was

sufficient to cure a case of jealousy of sixteen years' standing, in a husband of forty-eight, and another of thirty-two years' standing, in a husband of sixty. A susceptible, sulky character, a liar, husband of fifty years old, etc., etc.

As physicians, sexual passions in all their various phases, with their physical, moral and social injuries, being well understood and considered as morbid conditions, as diseases, and their treatment being in our reach, thanks to homœopathy, the question arises: Have we the right to be indifferent towards those who are affected with these diseases any less than with any other? Medical science has spent fortunes, time and brain-energy to find the etiological factors of various maladies in order to apply an intelligent and effectual treatment for their prevention and cure. Pasteur's antirabic treatment, which annually saves the lives perhaps of 200 people, made of him an idol. Behring's and Roux's diphtheritic antitoxin saves perhaps 4000 or 5000 young lives, and they are now idols. In every city we have special bodies by the name of Health Boards to watch and control contagious diseases. Must we not calculate the general ravage caused by this scourge (sexual passions), which undermines the entire humanity, and shall we not provide means for its prophylaxis and treatment? Already the laws in Germany and in France have been altered for those affected with psychopathia sexualis. They are no more considered as criminals, and instead of capital punishment, there is more compassion. Let us hope that soon no contradiction will exist between law and medicine by virtue of the progress of science and humanity, and that homœopathy shall be utilized in those ailments, as well to the great benefit of public and private morality, thus greatly contributing to the true moral, intellectual and material civilization of the human race.

---

EVOLUTION OF PULMONARY TUBERCULOSIS IN LUES HEREDITARIA TARDA. —Dr. Étienne, of Nancy, has followed up several cases of late hereditary syphilis in subjects who were weakly and infantile, in which pulmonary tuberculosis developed, and where, in spite of bad unhygienic conditions, the tuberculosis apparently went on to recovery. A sclerogenous process was brought about similar to that of tertiary acquired syphilis.—*La Semaine Médicale*, No. 21, 1898.

AFTER-TREATMENT OF CASES OF TRACHEOTOMY FOR LARYNGEAL  
DIPHTHERIA.

BY J. E. BELVILLE, M.D., PHILADELPHIA.

(Read before the Trousseau Clinical Club, May 3, 1898.)

MINUTE directions, covering completely the ground of operative technique, are to be found in text-book and journal, while post-operative treatment is generally slighted, or, if touched upon, it is with aggravating meagerness of detail. I wish it to be understood at the outset that the details of treatment outlined are based upon results in private practice and can be carried out at the home of the patient.

If circumstances will permit, a trained nurse should be in attendance. If this is impossible, the best substitute at hand must be made use of, and the one who takes the position must be carefully drilled in its duties and impressed with a due sense of their importance. Success depends in these cases more upon the constant watchfulness of the nurse than upon any other factor. The room in which the patient lies should be large and well-ventilated, and should be kept at a temperature of 80° Fahrenheit. The air about the patient should be kept moist with steam from a croup-kettle under a tent, or, what is much more agreeable to the patient and convenient for the attendants, the whole room should be kept moist. In a case of my own, this was readily accomplished by the use of a plumber's gasoline stove placed in an adjoining room. Over this a kettle of water was kept boiling and the steam conducted by a hose through a hole in a door opening near the patient's bed. There should be no intermittence in the supply, as it will manifest itself almost immediately in the patient's embarrassed breathing. The precautions already in force to prevent the spread of the disease will, of course, be continued.

If any anæsthetic has been given, it should have been chloroform, and any emesis that follows operation will be due to drugs given previously in attempts to dislodge the membrane and which have been idling about in the stomach unabsorbed on account of the blood-condition dependent upon deficient



aeration of the blood. These are quickly absorbed when respiration has been re-established. Diarrhœa may be caused in the same way. Both will need suitable treatment if they do not quickly subside.

If an aluminium tube is used, the same one will answer throughout the case. Should a silver tube be chosen, it will of necessity be changed as soon as it shows signs of corrosion. In either case the inner tube must be frequently removed, the outer at least twice a day. The tubes, whenever removed, must be thoroughly cleaned and disinfected with formalin or by immersion in pure carbolic acid.

The nurse should be carefully taught to remove the tube and reinsert it, and should demonstrate her ability to do this, as the tube may be accidentally displaced. It will be rarely necessary to remove the outer tube on account of obstruction by membrane, as the use of hydrogen dioxide is in most cases all that is necessary to remove such obstructions.

The nurse should be instructed to sit at the bedside, ready with mop of sterile gauze to catch any particle of membrane that may be coughed up. Neglect of this leads to accumulation in the tube which may entirely block it up and cause serious obstruction. A supply of feathers (plumage, not quill) should be at hand. (Pye.) They should be ready for use in a 1-1000 bichloride solution. At short intervals the nurse should introduce a feather as far down the tube and into the trachea as possible, give it a rotary movement, then quickly withdraw it. This will excite cough, and aid in the cleaning out of mucus and small pieces of membrane.

Once every hour, on the first and second days, and on subsequent days at longer intervals, being guided by the character of the breathing, she should spray out the trachea thoroughly with hydrogen dioxide. This can be used pure and freely. The point of the spray-tube should be introduced into the tracheotomy-tube, and the bulb of the atomizer be given several quick compressions. Cough is excited, and the frothy discharge should be quickly wiped away. This spraying, to be effective, should last for at least ten minutes. It is surprising, often, to see the marked relief given by one such thorough spraying. The breathing from being rough and stridulous becomes easy and quiet, and the patient drops off to sleep. An

experienced nurse will soon learn to appreciate the indications for the use of the spray and follow them.

As to removal of the tube, no fixed time can be set down. It will depend altogether upon the progress of the case. It will facilitate early withdrawal of the tube to use a Keen tube. This has an opening on the upper apex of its curved position, so that air can pass through the glottis into the lungs. In this way early trials may be made of the patient's ability to breathe through the glottis by closing the external opening of the tube. These patients, even when quite young, evince a disposition to nervous choking upon the withdrawal of the tube. In one of my cases the tube was not finally removed until the thirteenth day, and then choking continued until the patient was persuaded by a sleight-of-hand performance that the tube had been reintroduced.

After removal of the tube the wound closes quickly under a simple aseptic dressing. Infection of the wound, with development of membrane, should be treated, as the membrane in the throat, by the use of hydrogen dioxide and painting with pyokatannin. Secondary hæmorrhage should be dealt with on general surgical principles.

Paralysis of the palatal membrane is an annoying complication, as I can personally testify. In such cases semi-solid food is better swallowed than liquid. It may be necessary, for a time, to feed by the rectum or with the stomach-tube. Thirst may be allayed by letting the patient swallow small pieces of ice or by large rectal enemata.

Paralysis of the heart. The possibility of this should be on one's mind from the outset of the case, as it is much more easily warded off than treated when developing. Drop doses of the tincture of *nux vomica*, alternated with the tincture of *strophanthus* in the same dose, will do good service in supporting the heart.

Stimulants may be of benefit from the beginning, and as free and generous a diet as can be borne.

---

PHOSPHORUS IN MEASLES.—Violent and exhausting cough; dry cough, with desire to vomit or vomiting; typhoid symptoms, with loss of consciousness; watery diarrhœa; tongue coated with dirty, thick mucus; black lips; debility; complication, with bronchitis.

## THE TREATMENT OF SCARLATINAL NEPHRITIS.

BY CHARLES J. V. FRIES, PH.D., M.D., PHILADELPHIA.

(Read before the Trousseau Clinical Club, May 3, 1898.)

WITH varying frequency in the different epidemics we observe nephritis as a complication or sequel of scarlet fever. As a rule, it sets in during the end of the second or the beginning of the third week after the appearance of the exanthema, but it may develop later, though rarely after the fifth or sixth week. As to its causation there is a divergence of opinion. Early exposure to drafts and cold and other indiscretions during convalescence may play some rôle as a causative factor, but a great many, perhaps most of the cases, develop where all possible care has been taken. For this reason the view of a microbic origin is more frequently upheld. It seems likely that the microbes of scarlatina generate ptomaines which have a particularly damaging influence upon the kidney and the walls of its capillaries.

I feel assured that in some measure serviceable preventive measures should be employed, namely, through a proper stimulation of skin perspiration during the period of eruption as well as desquamation. In this regard I recall forty-seven cases treated during the past winter, all of which escaped nephritis save one, and this in mild form.

The treatment consists of daily warm baths at 95° F. Baths were given twice a day during the first week, and once a day during the second, with a duration of five to ten minutes. A good prophylaxis, moreover, requires rest in bed or in a warm room, avoidance of drafts and sudden changes of air, a liquid diet, and attention to the bowels until all symptoms of the disease have disappeared. The most frequent and typical of nephritis in scarlet fever is that of *glomerulo type*, showing proliferation and desquamation of the capsular epithelial cells of the glomeruli, sometimes combined with a capillary thrombosis.

Less frequent is the interstitial form, presenting hyperplasia of the interstitial connective tissue. The first symptoms directing attention to a nephritis are œdema, albuminuria, and



sometimes anæmia. Quite frequently physicians neglect to inform the parents of their little patients that nephritis may follow even the mildest form of scarlet fever (in fact the lighter the exanthema the more frequent and severe seems to be the nephritis), and days pass by that might have been useful in lessening the attack when a general œdema first calls the attention of the nurse to the now fully established disease. I deem it incumbent upon the physician to make it an object to fully instruct the parents of his fears, and especially to examine the urine three times a week during desquamation. Albuminuria may be present during the eruptive period, but when so is usually slight and not accompanied by anasarca. It is present in cases with high temperature, and is not due to nephritis, but to other changes, which favor the transudation of serum from the blood (probably functionary changes of the wall of the glomerular capillaries). Albuminuria due to scarlatinal nephritis is usually attended by the presence of epithelial cells, more or less red blood-corpuscles, leucocytes, hyaline, epithelial or blood-casts, but in exceptional cases there may be albuminuria while the urine is free from other pathological elements.

More important than the albuminuria is the amount of urine voided, for there may be complete anuria for twenty-four hours—or only the voiding of a few tea- or table-spoonfuls of turbid urine for this period. Its sp. gr. high, reaction acid, color varying, and an admixture of blood and uric acid crystals. Œdema may be absent during the entire course of the disease; however, in most cases it is noticeable, though greatly differing in intensity. Wherever it is light it usually appears only on the eyelids, dorsum of the feet, and about the malleoli. In other cases there is a general anasarca of the subcutaneous cellular tissue, more rarely with an œdema of the scrotum.

It must not be overlooked that œdema without albumin in the urine is not infrequent after scarlatina, and, I am informed through an article by Filatow (in *St. Petersburg Med. Wochenschrift*), is caused either by a weakening of the heart's action through disturbances of the nervous apparatus of the latter or by an alteration in the capillary walls under the influence of the scarlatina poison.

Hypertrophy and sometimes dilatation of the left ventricle of the heart is prone to develop in the course of scarlatinal nephritis, in consequence of the increased blood-pressure in the

aortic system, the decreased discharge of fluid by the kidneys, the illy-nourished myocardium, and the poisoned state of the nerve-ganglia of the heart under the influence of the scarlatinal ptomaine.

When the heart fails to provide compensation the pulse will be irregular and weak, or full and slow with the increased blood-pressure, and of no particular variation in mild cases.

The temperature seldom exceeds  $104^{\circ}$  F., keeps mostly between  $99^{\circ}$  F. and  $102^{\circ}$  F., occasionally is subnormal. A rise in temperature is often coincident with an increase of blood and albumin in the *urine*. Uræmia may set in without warning, but is usually preceded by anuria or a significantly diminished quantity of urine, vomiting, headache, convulsions, somnolence, slowness and irregular pulse.

*Prognosis.*—Cases of medium intensity usually terminate in full recovery. When, however, there is deficient urinary secretion, or a prolonged anuria with extensive and rapidly appearing anasarca, especially when complicated with œdema of the lungs, prognosis is unfavorable; or if, after an abeyance of the symptoms, *blood* and albumin again appear in the urine, our prognosis must be guarded.

*Treatment.*—The *first* requirement is absolute rest in bed in a well-aired room of equable temperature, between  $70^{\circ}$  and  $75^{\circ}$  F.

*Second.*—To give quick relief to the engorged kidneys by heightening the excretory functions of the skin and intestines, and by decreasing the work of the kidneys, through the institution of a proper diet.

*Third.*—To increase the usually greatly diminished urine, only to a certain degree can the excretion of the solid constituents of the urine be performed by the skin. Moreover, a forcible excretion by means of the sweat-glands is dangerous, because the loss of fluid is too great in comparison to the amount of urea excreted. If this loss is not readily made up for, there will be an accumulation of waste products—which favors the outbreak of uræmic symptoms. Diaphoresis should therefore be moderate and followed by the ingestion of plentiful fluids, among the diaphoretic measures. I prefer the warm bath of  $98$  to  $100^{\circ}$  F., in which the patient is immersed from five to ten minutes, and, if restless or frightened, for a much shorter period. Friction of the skin should be applied under the blanket.

Profuse perspiration usually results; if lacking, is facilitated by the administration of hot lemonade or a weak infusion of *jaborandi leaves* (or  $\frac{1}{20}$ -grain of pilocarpine nitrate, subcutaneous, for a child five to six years, I have often employed with seeming marvellous results when the foregoing procedures have failed). The latter drug should be used cautiously owing to its depressing effects, and never resorted to unless urgent symptoms demand, and then should not be repeated; and, if so, should be discontinued as soon as the urgent symptoms are relieved.

In mild cases one bath per day will suffice. Two or three can be given if necessary. Baths of a higher degree of temperature as recommended by Liebermeister I would not recommend, as they relax the cutaneous blood-vessels to such a degree as to cause the child to become uneasy, chilled or collapsed. The only contraindication is the complication of œdema of the lungs and eclampsia. Should the warm bath not be tolerated or unobtainable, it will often suffice to wrap the child in a sheet wrung out of hot water and surround it with a warm blanket; and to make the heat constant, warm water-bottles may be placed against the limbs and body—just outside of the wet sheet. As a rule the patients rest comfortably in the pack and perspire freely. Many observers recommend the hot-air bath—by means of a tent. I have never found this necessary, nor do I think it practicable.

Poultices applied to the lumbar region are serviceable in the intervals of bathing; they can be made of pulvis lini senniis or of one part pulvis sinapis to twelve of lini—mixed. Laxatives are often necessary; the most efficient I find to be pulvis glycyrrhizæ comp. or mixtura magnessi citras. Often it will be necessary to recommend large enemas of water, hot, especially when *anuria* is pronounced, urine then being passed when the enema is expelled.

*Diet.*—An absolute milk-diet, which has many advocates, I do not employ, as it is too rich in nitrogen. My experience has been that a richly nitrogenized food favors the retention of products of nitrogenous waste in the system, which the epithelial cells in their impaired condition are not able to dispose of, and the resulting intoxication will lead to an outbreak of that much feared complex of symptoms termed *uræmia*. Therefore I advise a diet containing fat and carbohydrates, as gruels,



soups of barley and rice, and other light farinaceous foods, cooked fruit, baked apples, fruit-jellies, orange-juice and young vegetables, and a limited amount of diluted milk. After the subsidence of the acute symptoms I allow white meat, eggs, and a larger quantity of milk or skimmed milk. *Diuretics* have from time immemorial been indiscriminately applied in this affection. The irritating effect of most diuretics is unquestionable, and I have never seen any good follow their employment. In ordering drinks for the purpose of allaying thirst, increasing diuresis, and washing away waste material, there is to be taken into consideration the amount of urine passed by the child and the degree of perspiration and elimination of fluids by the bowels; from this the physician should judge and prescribe accordingly. An accurate estimation should be made as to the quantity of fluids to be taken during the twenty-four hours, viz., pure spring-water and two or three wine-glasses of Vichy; also, lemonade may be ordered. A mild lemonade I consider an ample diuretic is made as follows:

R. Potassi bi tartras,	.	.	.	.	.	.	.	.	3i.
Limonis "fruct,"	.	.	.	.	.	.	.	.	i.
Aqua bulliens,	.	.	.	.	.	.	.	.	Oi.

The above amount to be taken in twenty-four hours by a child three years old, and sweetened to taste.

Alcoholics should be strictly and religiously prohibited, owing to their irritating effects upon the kidneys. Even where a weak heart seems to invite their use I prefer other stimulants, such as strophanthus, which I consider superior to the much-lauded digitalis. Slight hæmaturia is often more relieving than injurious. When obstinate and combined with *anæmia*, the ordinary tincture of iron in one to three-drop doses every two or three hours is very efficient. Ergot is less reliable, and astringents like tannin are bad.

Where œdema of the lungs is threatening, strophanthus, boldly administered, I have found to act beautifully.

Remedies should be employed upon strict homœopathic indication; those more serviceable are verat. verid., gelsem., rhus tox., hepar, ailanthus, camphor, cuprum, zinc, apis, bell., mercurius. Cantharis and arsenicum should enjoy the most distinction.

## CORRESPONDENCE.

### MILK FOR INFANTS.

EDITOR HAHNEMANNIAN MONTHLY:

We note in your last issue a valuable essay upon the "High Rate of Infantile Mortality," and yet we think there is one allusion in it that is based upon an erroneous impression. We refer to the classifying of "Alderney milk" with candy, peanuts, etc., as injurious to infant life. If the milk of the Channel Island cow is less desirable for infant feeding than that of other breeds of cows, because of its well-known greater richness in fat, it is of importance that this objection should be speedily recognized; for, at the rate of change to Jersey and Guernsey cows now progressing in the dairy herds of our country, another twenty years will probably witness the practical extinction of all other breeds. But we think we shall demonstrate that this change is fraught only with good to our infant population.

We assume in the outset that cow's milk is not fed to infants (of such age as to be wholly dependent upon a milk diet) without a modification thereof, and we are aware that such modification is varied according to the experimentally determined needs of the individual infant. The general trend, however, of this modification embraces a reduction in the proportion of the casein by the addition of water, a change made necessary by the relatively larger amount of casein found in cow's milk.

To facilitate the discussion of the subject, we give the following analyses of milk of the human mother and of the cow. They are average or composite results derived from data at hand, and published by American, English, German and French authorities:

		Water.	Fat.	Casein and Albumin.	Sugar.	Ash.
Human milk,	.	87.60	3.84	2.40	5.88	.27
Cow's milk, .	.	87.44	3.60	3.51	4.75	.68

In the *Analyst* (London) for May, 1893, page 139, occurs a review of a pamphlet by J. F. Lehmann, of Munich, in which the author proposes to make an artificial human milk by diluting cow's milk with half its volume of a solution of milk sugar. Also, the *Analyst* for September, 1894, page 206, has an abstract of a paper published in the *Chem. Zeit.* by Lehmann and Hempel in which occurs the following: "In order to make an artificial human milk which shall resemble the natural secretion as closely as possible, cow's milk should be diluted with water until its casein content is identical with that of human milk, and cream, milk sugar and white of egg should be added until the mixture contains the proportion of fat, sugar and albumin in human milk."

We believe the usual recommendation and practice of physicians is in harmony with the views thus expressed by Lehmann, though, as before stated, the needs of each infant require a special study. A comparison of the above-given analyses demonstrates the need of the addition of cream or fat, as well as water, to the milk of the general cow, for, while the addition of water to the extent of one-half the volume of the milk is needful to reduce the casein in cow's milk to the proper proportion, the content of fat is thrown out of balance by the addition; for the amount of fat in human milk and in cow's milk are, as seen in the above analyses, nearly identical. In the addition of cream to milk there is an element of uncertainty and of danger. Every purveyor of milk and cream well knows the difficulty of commanding for his customers fresh, sweet, faultless cream, and, almost of necessity, the cream supply is of greater age than the milk supply. The milk supply may be carefully selected and guarded, and the added cream may spoil all. To say the least, two approaches of danger are to be watched instead of one. If, then, a natural milk supply could be found that contained a much larger proportion of fat with but slight increase in the casein, would it not be a most happy attainment? Now, it would seem that our all-wise Father in Heaven, in condescension to the needs of that numerous class, the bottle-fed infants, has given us the Jersey and the Guernsey cow, for the milk of these cows contains about 5.25 per cent. of fat, or about one-half more fat than the milk of other breeds, while the amount of the casein



is only slightly greater. Consequently, when we add water to the Alderney milk to the extent of one-half the volume of the milk we have produced artificial human milk, so far as the water, the fat and the casein are concerned. It would seem, then, that Alderney milk might be very properly commended as best adapted to infant-feeding.

Very respectfully,

GEO. ABBOTT.

PHILADELPHIA, May 16, 1898.

INTERMITTENT CYCLIC ALBUMINURIA IN THREE MEMBERS OF THE SAME FAMILY.—Dr. P. Latour (Lyons) has had occasion to observe three brothers affected with intermittent albuminuria (Pay's disease). They were children of a father who was eczematous and inclined to obesity, and of a mother who was neurasthenic, arthritic, and a sufferer from neuralgia. For six years the writer has followed these cases, and always in all three has he been able to demonstrate the presence of albuminuria about three hours after rising, while not a trace of albumin was to be found at any other hour of the day. In two the proportion of albumin was 0.40 per cent.; in the other, 0.60 per cent. Nevertheless, during all this time, the children have developed well enough, and nothing pathological can be observed in their circulatory or renal apparatus. All three are of a "nervous" tendency; one has suffered from convulsions in infancy. Similar cases have been published by Heubner, where three brothers were affected. Moxon has also recorded the case of three brothers with this disease, and recently Schon has observed three chlorotic sisters who all presented intermittent albuminuria. In all these cases the usual treatment of Bright's disease has been without effect, and if, at times, the albuminuria has disappeared, it has been brought about by climatic treatment, sojourn at the seaside, etc. Also the fact that, after having presented the albuminuria for years, these patients were well, presented no circulatory disturbances, and underwent normal development, speaks in favor of the disease *not* being a nephritis, in the strict sense of the term. It probably is dependent on a morbid state. Tessier would trace it to a dyscrasia, probably most frequently the gout.—*La Settimana Medica*, No. 27, 1897.

Ostwalt—*La Semaine Medicale*, No. 32, 1897—communicated to the Société de Biologie of Paris two cases of cyclic albuminuria with ocular complications. The first was that of a woman of thirty-two years, in whom the albuminuria was preceded by recurrent intra-ocular hæmorrhages of the right eye. The second was a young man of sixteen years, who presented, during the course of his albuminuria, a patch of chorio-retinitis near the papilla of the left optic nerve. Later there appeared a right-sided peripheric facial paresis, which was cured in six or seven weeks. In both these patients he is inclined to regard as the original cause of the troubles the albuminuria and the intra-ocular disturbances, a profound disturbance of nutrition, and an alteration of the tissues, so that, under unfavorable hydrostatic conditions—the upright position—the albumin passes easily into the urine or hæmorrhages, and perivascular inflammatory foci form.

## EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

## MEDICAL RESULTS OF THE WAR.

ALTHOUGH at the present writing there are two great events impending, viz., the beginning of the work of the Board of Medical Examiners of Pennsylvania and the Fifty-Fourth Session of the American Institute of Homœopathy, either of which might profitably engage our attention, we feel inspired by the belligerent atmosphere surrounding us to turn away from such peaceful scenes to the contemplation of the sterner aspect of war, and some of the results which are likely to follow it within the medical profession.

War, however horrible, cannot be regarded as an unmixed evil, Mr. Love and the Universal Peace Society to the contrary notwithstanding, and it may prove comforting to point to one or two of the benefits to our profession likely to follow, without admitting that a war would have been justifiable simply to bring about these results.

One result which concerns us more particularly as homœopaths, and one which can hardly fail to be realized, was referred to by us last month—we mean the breaking down of the barriers which have hitherto prevented our entrance into the naval and military service of the United States. The result of the interview of the delegation sent to Washington by the Germantown Society with President McKinley cannot but be gratifying to the profession. The entire question was put upon the only possible logical basis, the basis of competency. Discrimination against a competent applicant on account of sect would be regarded by the President as ground for investigation and interference, according to the assurance given by him to the committee. More than this we could not ask, and less than this we could not demand. We trust that only our best men may apply, so that there may be no question of fitness.

The appointment of homœopaths to responsible positions in the military service in several of the States is a further recognition of the same principle of justice so long denied us.

We need hardly fear that "when this cruel war is over" there will be any attempt to erect anew the barriers of prejudice behind which the "regulars" have for so many years been securely dodging, provided we succeed in getting in enough good men who shall prove by their works that their appointment was not a mistake.

We need not fear that amalgamation or absorption will result. Let our men be true to themselves and the result can only be favorable. By their conscientiousness, as well as by their liberality, but most of all by their skill and success, they have it in their power, unostentatiously but surely, to enlighten their old-school colleagues and to elevate the plane of medical science. Those of our number who may be successful in entering the service at the present time will assume a great responsibility; they must maintain the honor of our school; in their hands rests, in a great measure, the future recognition of Homœopathy by the Government.

Another result of the war, one which concerns all physicians and surgeons, will undoubtedly be the further rational development of the germ-theory of disease, in connection with its practical application to asepsis and antiseptis in the treatment of wounds, and to the prophylaxis and treatment of malarious and infectious diseases, the most formidable foes with which our armies will have to contend. We all know the modifications which Listerism has undergone, and we feel confident that the present technique of antiseptic surgery will be considerably altered, probably in the line of simplification, by the experience to be gained in active warfare. The exigencies and emergencies of active service will gradually eliminate the non-essential, and teach a better and clearer understanding of the essentials.

In the case of disease, the cumulative records, rendered possible by observations of hosts assembled under similar circumstances, will emphasize the fact that the test-tube and the human organism do not present identical conditions for the study of germs, and will demonstrate that the experiments in the bacteriological laboratory have been assigned too high a rank as infallible guides in the treatment of disease.

In no other science but that of medicine would such violent and arbitrary overriding and disregard of unfavorable testi-



mony ever have been attempted or allowed as characterize many of the dicta of modern medicine, based upon theories derived solely from laboratory research.

We trust that, after the experience to be gained in this war, under circumstances peculiarly favorable for the test, there will be a healthy reaction, and a consequent modification of the present standpoint from which there will be a broader and more generous recognition of other factors of disease than is at present accorded by the upholders of the germ-theory.

No matter what the ultimate fate of Cuba may be, another unavoidable result of the war will be improved sanitary conditions on the island. It seems to be pretty generally acknowledged that the prevalence, if not the very existence, of yellow fever there is due to the unsanitary conditions allowed to exist. Besides undoubtedly interfering with the commercial growth and prosperity of the island, the existence of this disease is a constant menace to our own country, and its eradication or suppression would in various ways be of almost incalculable advantage to the United States.

According to the most reliable authorities there are comparatively few places on the island of Cuba where yellow fever has a seeming right to be considered endemic, and even there it is so only by reason of the criminal neglect of sanitary precautions. We cannot doubt that, in the ultimate adjustment of the present misunderstanding, provision will be made for the correction of this condition.

The task falling to the lot of the surgeon-general's department of the United States is truly a formidable one. The general state of "unpreparedness" in which the hasty declaration of war found every department has had its effect in making this task even more difficult than it would otherwise have been. The difficulty of preserving the health of raw recruits, exposed to the depressing effect of long waiting in camps but poorly provided even with the few requisites necessary to make camp-life endurable, is great, but that which will have to be confronted when these troops are transferred to the malarious influences of a tropical country seem almost insurmountable.

In this connection we would refer to certain statements made by yellow-fever experts which we think are calculated to do

harm, but which we hope may not serve as guides in the attempt at sanitation. Basing their views upon an exclusive germ theory, they have stated that personal precautions in seeking to avoid disease are as good as useless; that the only means of safety concern the masses, and the location of their camping-grounds. While this may be correct as far as absolute security is concerned, no doubt emergencies will arise where careful selection of routes and camps will be impossible, and, in such cases, we surely think that the soldiers should be prepared by instructions, promulgated by their medical superiors, hopefully to take such individual precautions as have in many similar conditions proved effective. Fortunately, we find other physicians of experience, though perhaps not so well known as experts, urging the importance and benefit of personal sanitation and care. In an excellent paper in the *Monthly Cyclopædia of Practical Medicine*, the editor, Dr. Sajous, refers to a recent statement of a prominent pathologist that there are only two theories as to the mode of transmission of malarial infection worthy of consideration, and characterizes it as a dangerous one upon which to act when prophylactic measures are to be put into effect. The two theories are, that transmission occurs aerially, or by inoculation through the agency of suctorial insects. Dr. Sajous points out that experience has proved that "there are many factors, objective and subjective, which, acting more or less conjointly, can give rise to malarial fever." The experience of travellers in malarious Africa and elsewhere has demonstrated that much can be done to avoid attacks of fever by having regard to these often-neglected factors. A striking degree of immunity was arrived at by drinking only of boiled water; by avoiding bathing in the waters of malarious districts, and, finally, by taking daily small doses of quinine, preferably the hydrochlorate. The author, in agreement with our own line of thought, says "the experimentally demonstrated data at our disposal concerning the ætiology of malarial fevers are insufficient to serve as reliable guides in the selection of the proper prophylactic measures to be used in a campaign so fraught with climatic dangers as that just begun." Further experience will also show that the diseased human organism is a more trustworthy field for the study of disease than the test-tubes and culture media containing their supposed cause.

This war will also, no doubt, have an influence upon the Commissary Department. Diet becomes a question of the greatest importance in the preservation of the health of troops. A ration suitable for the Klondike would be sure death in Cuba. We all remember the beneficent part played in the Civil War by the odoriferous onion, a part perhaps to be assumed in our present entanglement by the equally boisterous garlic.

In all these attendants and results of the present war it is possible for the men of our school, even if occupying only subordinate positions, to make their influence felt. They have been taught habits of close observation, they have learned, or should have learned, the importance of the apparently insignificant, and therefore, in their experience and their reports of the same, will be less likely to overlook or ignore factors in the results obtained than those more accustomed to treat disease and remedies *en gros*.

All this presupposes that the men applying for position will have scientific as well as patriotic, pecuniary, or ambitious aspirations.

In all events, we cannot but feel that the medical results of the war will be favorable to the liberal advancement of medical science, and thus prove a not altogether unmixed evil.

Man proposes, but fortunately there is also a Providence which disposes.

---

ON THE FAMILY FORM OF ACUTE, CIRCUMSCRIBED ŒDEMA.—Dr. H. Schlesinger, of Vienna, records a family of four generations where acute, circumscribed œdema affected five members in nearly the identical manner and at about the same age—twentieth year. The attacks would commence with a feeling of oppression and distress, followed by a peculiar erythema and finally suddenly appearing œdema, which occasionally were substituted by vomiting and colic. These latter symptoms indicate an involvement of the mucous membranes. He explains the symptom-complex as an angio-neurosis, and classes it together with intermittent dropsy of joints, intermittent vomiting, the intermittent œdema of Basedow's disease, and bronchial asthma.—*Muenchener Medicinische Wochenschrift*, No. 16, 1898.

Prof. C. Lange, of Copenhagen, asserts that acute, circumscribed œdema, urticaria and similar conditions are due to uric-acidæmia. I do not think that Haig, in his classic work, *Uric Acid*, mentions these states as of uric acid origin.



## GLEANINGS.

---

**ACUTE LEUCÆMIA.**—A. Fraenkel (Berlin), in a paper read before the XV. Congress fuer Innere Medicin on acute leucæmia, states its essential characteristics to be a hæmorrhagic diathesis, which appears with swelling of the liver, spleen and glands, and the peculiar blood-findings. In seven years he has observed twelve cases. Some had been diagnosticated as purpura hæmorrhagica, but the examination of the blood excluded this disease with certainty. In the liver and kidneys typical heteroplastic leucæmic proliferation occurs. The blood-changes are very characteristic, exclusive increase of the mononuclear leucocytes, which are found in differing sizes. Ehrlich's neutrophile granulation is not observed. Fraenkel designates this form as lymphocytes, but not identical with the former so-called, and, therefore, the process is an acute lymphocyætæmia. In one of his cases there was worthy of note: 1. A peripheral facial paralysis, depending on a leucæmic neuritis; the leucytes had immigrated into the nerve-trunk. 2. The relation of the red to the white blood-corpuscles, 1:94. In spite of that, he diagnosed acute leucæmia, which was confirmed by the necropsy. 3. The examination of the urine showed an enormous excretion (12 gms.) of uric acid in forty-one hours. Even from the blood was a great quantity obtained (22 mgms. from 100 ccms. of blood).—*Muenchener Medicinische Wochenschrift*, No. 26, 1897.

The next day Benda (Berlin) reported on seven cases of the same disease, one of which was diagnosed only on the necropsy table. The splenic tumor is not so large nor so soft as that of infectious diseases. He regards alterations in the walls of the veins as the cause of the hæmorrhages.

**TUBERCULOSIS FOLLOWING LOCAL GLANDULAR TUBERCULOSIS.**—Dr. Meyer has observed a form of tuberculosis in soldiers where, after tuberculous swelling of the lymphatic glands, the lungs became affected, which pulmonary complication pursued a rapid course, with death from meningeal complications or generalization of the infection. In another variety which he noticed particularly amongst the Algerian Arabs, the lungs became affected after a dry pleurisy.—*La Semaine Médicale*, No. 21, 1898.

I have recently observed a negro who developed pulmonary tuberculosis after a left-sided enlargement of the cervical glands, of tuberculous origin. The glands suppurated out, though at first there was a voluminous mass, and seemingly quite an extensive pulmonary complication ensued, with fever, râles, elevated temperature, cough, and, in short, he seemed doomed. Yet these symptoms gradually disappeared, and to-day he appears in fair condition, though the lungs present signs showing infection of both apices. Probably these latent conditions are only awaiting a kindling spark to begin again. I have seen several such cases of pulmonary tuberculosis following a dry pleurisy. Osler directs attention to the frequency of pleurisy being tuberculous. Bowditch also has thoroughly studied this question. The French have studied this matter zealously.

FRANK H. PRITCHARD, M.D.

**MALARIA AND THE CUBAN CAMPAIGN.**—Dr. C. E. de M. Sajous, in an article under the above title, after a lengthy review of the reports of the French Medical Director on the Madagascar campaign, the English notes on the Niger-Soudan campaign of 1896, and the observations of explorers and other experts on the conditions prevailing in tropical malarial districts, arrives at the following conclusions: The following prophylactic measures, carried out simultaneously, become necessary in malarial districts to insure adequate protection.

1. To avoid contamination through respired air and inoculation by insects:

Unacclimatized men, white or black, should not be employed for the digging of trenches, the erection of defences, or any other kind of work involving upturning of the soil.

Natives should alone be utilized for this work.

High ground should be selected for camp-sites, windward, if possible, of any swamp, pool, stream, etc., that may be in the neighborhood.

The men should sleep as high above the ground as possible (not less than two feet, and, if practicable, from twelve to fifteen feet) and be provided with mosquito netting. While crossing malaria-laden forests, glens, lowlands, swamps, etc., the men should be ordered to avoid talking.

2. To avoid contamination by water:

When water from malarial regions is alone available for drinking purposes, it should be filtered, or, preferably, sterilized by boiling.

Bathing should not be permitted when water from a malarial region can alone be obtained, but washing of the body with such water is permissible, provided carbolic acid soap be employed.

3. To prevent the development of malarial parasites in the blood:

Four grains of hydrochlorate of quinine should be administered morning and evening, during meals, as a prophylactic, beginning two days before the malarious region is reached.

4. To conserve the general powers of resistance of the economy:

Regular and frequent periods of rest should intersperse long marches. Drenching and wading through streams should be avoided when possible. Varied and adequate food should be furnished.

The head should be so protected as to secure a maximum amount of coolness under all degrees of temperature, a head-gear such as the solar tepé being furnished for this purpose.—*Monthly Cyclopædia of Practical Medicine*, May, 1898.

WOODWARD D. CARTER, M.D.

**SENECIO AUREUS.**—This drug will be found indicated in the irregularities of menstruation in young girls when the flow is suppressed by moist cold, especially by getting the feet wet, in menorrhagia when the hæmorrhage is copious and persists for a long time so as to bring about anæmia. It is useful in girls who tend towards chest affections, with the menses suppressed for several months, and who become pallid, weak, and complain of a dry cough, and expectorate blood. (Tuberculosis? Does senecio cure these subjects? Such a statement is rather loose.) He asserts that our drug will re-establish the menstrual flow and cure the cough in a short time.

*Hæmorrhages from all the mucous membranes:* coryza with epitaxis, bloody expectoration, hæmoptoe, catarrhs of all the mucosa, with a hæmorrhagic tendency and congestion of the kidneys, with hæmorrhages. In chlorotic

girls with uterine, renal or vesical hæmorrhages, senecio renders great service. — *Il Secolo Omiopatico*, No. 4, 1898.

Dr. S. Talcott—*Journal Belge d'Homœopathie*, No. 6, vol. iv.—reports a case of puerperal mania as cured with senecio aureus, where, after the suppression of the lochia, a puerperal mania developed which resisted the usual remedies, acon., bapt., bell., hyos., puls. and stram., and greatly improved under senecio 3x, a drop every two hours. At the same time the flow reappeared. A relapse occurring, bell. was administered, to be followed by sen., which led to a prompt and lasting cure. Senecio is very highly recommended by allopathic writers in renal hæmorrhages. The eclectics consider it to be an emmenagogue, and administer it not only to stimulate the function, but also when in excess or otherwise deranged.

TREATMENT OF BERI BERI.—Dr. Pinart, of Barcelona, finds our chief remedies at first to be bell. and arsen., alternated. If œdema sets in, suspend these drugs and give apis. If the type be the fulminating, camphor, 3x, every quarter to half hour. Gelsem. will be useful for the subsequent paralysis. As auxiliary drugs one may need calc. carb., china, digital., veratr. alb., hellebor., the latter when apis fails. Caust., physostigma and phosphor. are to be thought of besides gels.

CLINICAL FORMS OF PULMONARY TUBERCULOSIS IN CHILDREN.—Prof. Comby, of Paris, states tuberculosis to be exceptional before the third month of life, which speaks against direct heredity; and, indeed, the frequency increases from the first months of life, the minimum, to the second year, the maximum. This fact would seem a powerful argument for contagion. The child, creeping about the floor, breathes in the infectious dust which, localizing itself in the tracheo-bronchial glands, thence to invade the lungs or other organs after a longer or shorter incubation. One may affirm that children become infected, not through the digestive tract, but through the respiratory passages. Among twenty-four little patients who were carefully followed up, he was able to distinguish the following clinical types: *afebrile tuberculosis*, ten cases, either with miliary involvement or with cavities. These children, varying in age from four to fourteen months, first presented diarrhœa, vomiting and emaciation; they were thought to be dyspeptic or athreptic. *Febrile tuberculosis*, twelve cases, with elevation of temperature, bronchial râles and souffles. One thought them to have pneumonia or bronchopneumonia. In some cases there were gastric disturbance, prostration, a typhoid state, so that a diagnosis of typhoid fever or meningitis was made. *Ordinary ulcerating phthisis*, two cases, resembled that of adults. In nurslings, all these varieties develop more rapidly than in older children or adults. Tuberculosis in children, as is well known, has a tendency to become generalized. In certain children, measles, whooping-cough, the grippe and diphtheria had a most aggravating influence.—*La Semaine Médicale*, 21, 1898.

Prof. Haushalter, of Nancy, France, also is an advocate of the tracheo-bronchial origin of pulmonary tuberculosis, which localization is strong proof of infection by inhalation. Osler points out the frequency with which pulmonary tuberculosis follows measles and whooping-cough. Tuberculosis in children, says Haushalter, is rarely localized, but nearly always generalized.



A CASE OF CHRONIC PARENCHYMATOUS NEPHRITIS, UNDER OBSERVATION FOR TWO YEARS, AND PURSUING AN ABNORMALLY FAVORABLE COURSE.—Dr. Strauss, of Berlin, reports the case of a man of twenty-one, who, December 12, 1895, was received in the III. Berlin Medical Clinic with typical symptoms of a serious parenchymatous nephritis: oedema of the face, scrotum, prepuce, and of the legs, as well as ascites and double hydrothorax. His urine was increased, turbid and hæmorrhagic, with albumin, casts, leucocytes, red blood-corpuscles and epithelia. This condition had followed a sore throat, without exanthem. For a whole half year no change occurred; he presented the picture of uræmia, and his ascites had to be punctured five times. About forty-five litres of an opalescent, *soapy looking* fluid was withdrawn. Immediately following the last paracentesis, which was preceded by acute uræmia, with three convulsive seizures, relatively rapid recovery, in a few weeks, apparently succeeded. In fact, a complete change took place in the symptoms. From now the quantity of urine varied between two and three litres, it became clear, lost its hæmorrhagic character, the albumin sank to  $\frac{1}{4}$  of 1 per cent. In May, 1897, he was taken as a nurse in the Charité Hospital, and in spite of the trying work he underwent no aggravation in his condition. Even now the apex heart-beat is in the left mammary line, and palpitation as well as sphygmograms of the radial artery show no decided elevation of the pulse-wave. As a secondary contracted kidney is to be assumed as threatening, yet there must remain sufficient active renal parenchyma to eliminate competently. As to the soapy-water appearance of the ascitic fluid, he has frequently observed this phenomenon in the pleural exudates, the ascitic fluids, as well as in the serum of oedema and drawn blood in parenchymatous nephritis. This patient for six months was confined in bed, living almost entirely on milk and vegetables. The importance of this regimen was noted in a case of cyclic albuminuria where, with calculous pyelo-nephritis, three to five hours after a meat-diet a sediment of leucocytes was obtainable, while the following day, after discontinuing this, it was not noticed.—*Berliner Klinische Wochenschrift*, No. 18, 1898.

Wagner, in his work in Ziemssen's *Handbuch der Speciellen Pathologie und Therapie*, Bd. ix. i., third ed., 1892, regards the prognosis in an especial form of Morbus Brightii, the chronic hæmorrhagic nephritis, as better than in the usual parenchymatous variety. Out of six cases observed by him four ended in recovery. Though he states that this pursues a chronic course without dropsy, yet Prof. O. Heubner—*Ueber Chronische Nephritis und Albuminurie im Kindesalter*, p. 20, 1897—in children has observed such cases, where, after a course of several months, with dropsy, a definite recovery followed.

THE ELIMINATION EN MASSE OF TYPHOID BACILLI, THROUGH THE KIDNEYS, IN THE CONVALESCENCE OF TYPHOID FEVER.—Dr. J. Petruschky, of Danzig, alluding to the dangerousness of typhoid fever patients' urine as having been pointed out by English writers, was able to observe in fifty cases, which he had treated in 1897, three in which a massive elimination of the bacilli of the disease could be demonstrated, and in one case it persisted two months, succeeding a renal hæmorrhage. In a second it lasted two weeks. Here it began on the tenth day after a revival of the fever, without any other sign, as a renal hæmorrhage, and without coarse excretion of albumin, and persisted over four weeks. In the third case, six days after defer-

vescence, for eight days there was a massive excretion of typhoid bacilli through the urine. Here albumin was noticed once as a sign of renal disease. He reports, in concluding, a case where the presence of bacilli was detected indirectly, and its infectiousness demonstrated.

A patient, stupid with fever, used a half-emptied champagne-bottle, in the absence of the nurse, as a receptacle for his urine. In giving the wine to the patient she noticed a peculiar turbid settling in the bottle, and taking a sip of it before letting him drink, she at once saw that it was something else than champagne. Vomiting soon followed, and after a period of incubation of twelve days she fell sick with typhoid. From these cases he advises disinfection of the urine and all that come into contact with it, in typhoid cases, both during the disease and convalescence.—*Weiner Medizinische Presse*, No. 18, 1898.

THE CLINICAL SYMPTOMS OF THE CIRCULATORY APPARATUS IN DIPHTHERIA.—Dr. R. Schmaltz, from careful observation of 312 cases of diphtheria, has found in the first stage of the disease the pulse to be, if one except extreme frequency, of neither prognostic nor diagnostic importance. After subsidence of the local phenomena the frequency either increases or falls to the normal; in a quarter of his cases an *abnormal slowing* set in. Further, after the middle or towards the end of the second week of the disease, instead of the former slowed or *seemingly normal* pulse-rate, a *secondary increase* may be noticed, with which serious symptoms may supervene. This requires, if it be observed on getting up, an immediate return to bed. In 151 cases there were decided signs of cardiac weakness, and not that cardiac debility of the weakening effect of the diphtheritic attack itself. One very important feature to remember is that he has never noticed a *sudden cardiac paralysis* appearing without warning. (Nor I either.—*Trans.*) An abnormal frequency or slowness or a weakness will call attention to threatening heart weakness. *Yet a normal pulse-rate is no guarantee of safety.* Arrhythmia is also ominous, and even a regular and a strong pulse do not assure security. The serious signs of cardiac debility are: Somnolence, or restlessness, paling of the face, appearance of fainting attacks, vomiting, colic and swelling of the liver. In 55 cases examination of the heart revealed dilatation, and although alterations in frequency of pulse and arrhythmia were present, yet only a third of these presented other signs of cardiac weakness. Cardiac dilatation of itself does not offer a gloomy prognosis. On auscultation there were accentuation of the secondary pulmonary sound, weakening and reduplications of the valve-sounds, as well as formation of murmurs, which were nearly all systolic.

Frequently albuminuria precedes the signs of failure of the circulatory organs; serious heart weaknesses usually follow severe diphtheritic attacks. *Every disturbance of circulation deserves serious consideration*, as one cannot say beforehand whether a cardiac paralysis will not develop. The heart murmurs often remain persistent for a long time after, possibly always; out of 38 patients with heart disturbances who were examined six months to a year after being discharged, 27 presented cardiac disturbances—mostly systolic murmurs. But the presence of a former valvular incompetency does *not* make the prognosis more unfavorable. As to treatment, rest in bed and cold are of the most importance; in heart weakness, stimulants, as camphor; in threatening collapse, alcohol. *Bland diet!* He never noticed any effects

from digitalis worthy of confidence.—*Deutsche Medicinische Wochenschrift*, No. 11, 1898. Nil Filatoff (*Kurzes Lehrbuch der Kinderkrankheiten*, p. 208, 1897), says that œdema of the cellular tissue of the throat is of bad prognostic omen, and threatens danger from heart paralysis during the convalescence.

THE DIAZO-REACTION IN NURSING-CHILDREN'S URINE.—Dr. Umikoff, of St. Petersburg, finding that a healthy child's urine will not give the diazo-reaction, remarks that in catarrhal pneumonia, diphtheria, and varicella no reaction occurs. If it be noticed in erysipelas and measles, and if it be intense, *it is an ominous sign*. Fever has no importance in its production. Frequently the reaction is observed in the last days of life, whatever be the disease. All in all, an intense diazo-reaction is a *signum mali ominis* which denotes a fatal outcome.—*Hospitals-Tidende*, No. 12, 1898.

FRANK H. PRITCHARD, M.D.

REMARKS ON THE TREATMENT OF STONE IN THE BLADDER WHEN ASSOCIATED WITH HYPERTROPHIED PROSTATE.—Keyes states that when the surgeon is called upon to select a line of action in contemplating the double condition, hypertrophied prostate plus stone, he may well say to himself, "I do here perceive a divided duty; because, as a malady, stone in the bladder cannot be considered a single morbid entity." The stone plays a double rôle. While it undoubtedly aggravates the subjective symptoms for which the patient seeks relief, it is not of itself the cause of all of these symptoms when the prostate is also pathologically modified. Indeed, when a stone is phosphatic it is nothing more than an objective symptom of the catarrhal process in the bladder, due to the prostatic malady; and, although the stone may and does mechanically intensify the subjective symptoms, pain and vesical irritability, and while its removal is imperative if a cure be aimed at, it is no more logical to expect a cure of the complex malady by removing one of its objective symptoms—the calculus—by crushing or cutting, than by removing one of its subjective symptoms—pain—by opium.

It is unnecessary here to more than mention the distinction between primary acid stone, forming in a bladder otherwise normal, and mechanically, after a time, lighting up catarrhal symptoms; and secondary phosphatic stone, itself a direct result of a catarrhal state of the vesical mucous membrane plus obstruction to urinary outflow. This distinction is to-day thoroughly understood and accepted.

But the question at once presents itself: granting that a phosphatic stone may be considered a symptom of other conditions, and assigned a second place in deciding upon such remedial means as shall address themselves to the entire morbid state, yet what shall be our course when, although the prostate be enlarged, the stone is primary, uric acid or oxalate, and notably when the stone is quite small? Is the surgeon justified under such circumstances in subjecting his patient to a grave operation, lithotomy, with or with prostatectomy, when the much less serious alternative, litholapaxy, might more safely encompass the necessity, in so far as the calculus is concerned?

Now it must be granted that if the stone could be eliminated by some act of magic, the case would resolve itself into one of ordinary prostatic enlargement, to be treated upon its own merits, and therefore the question proposed may be answered by another, namely, can the stone be entirely removed without serious irritation due to the process of removal? And, secondly, if the



stone can be so removed, will the result be generally satisfactory to the patient?

And this is the nucleus of the whole matter.

Keyes again asks the question, "Can ever an experienced lithotritist remove the last fragments of the calculus in every case when the prostate is large? Secondly, if he could so remove them, would the patient be satisfactorily well?" He answers them by an unqualified negative.

So grave is it, and so far from being ideal in the functional results that it guarantees, that we hear less about prostatectomy now than formerly, and widespread efforts are being generally made to substitute milder operative procedures, orchidectomy, vasectomy, and the Bassini operation for cutting down the prostatic bar by electricity from within.

Prostatectomy is not now generally advocated by the Guyon school in France. The tendency there is to return to the catheter with asepsis. A serious opposition is steadily growing up against orchidectomy, which has been much overdone, and is not, in Keyes' opinion, as devoid of risk to the patient's body and danger to his mind as has been claimed.

Keyes believes vasectomy to be of little value in reducing the size of the prostate. He considers prostatectomy the operation of choice in prostatic cases, when the patient cannot get along with the catheter and asepsis.

But there are two kinds of prostatectomy, one the total evisceration of the capsule of the gland from above or from below, and the other partial prostatectomy, cutting away third lobes, bars, horse-collar overgrowths, and encleaving interstitial prostatic tumors.

The last-named group of operations gives the best results, if the floor of the urethra be lowered by gouging out the vesical prostatic orifice upon the floor with an emporte-piece, or cutting it well down and forcing it to heal open by the prolonged wearing during the granulating process of a large perineal tube.

Total evisceration of the prostatic capsule does not always cure. The writer has seen functional disturbance persist after it and partial incontinence, while its risk is greater than that of partial prostatectomy, because it is a more violent and more extensive operation.

Moreover, as we all know, it is not the size of the prostate that makes it obstructive or causes it to yield subjective symptoms. Many a man with a very large prostate empties his bladder, has no residual urine, and does not greatly complain; while another with practically no general enlargement, but with a third lobe or prominent bar—thus making his prostate actively obstructing—will suffer the torments of the damned, and embrace any operation and take any risk which promises to relieve him from his torture. It should, therefore, be the surgeon's object to remove the obstructing portion of the prostate rather than to take the organ away in bulk, since the bulk alone, generally, does little damage.

Here, then, are just the conditions that we sometimes find typically illustrated in a case of prostatic enlargement complicated by stone, namely, a prostate slightly or greatly enlarged, a tender prostatic urethra, which if traumatically irritated by the lithotrite and tube in efforts to remove a stone will resent the injury, and a residual accumulation of urine which cannot be properly attended to on account of this very prostatic obstruction and irritability, making the kindly use of the catheter impossible.

In such a contingency it is clearly the surgeon's duty to cut, and if he cuts he has the door open; and with the patient's consent it is only fair to add somewhat to the operative risk by prolonging the lithotomy into a partial prostatectomy for the ultimate good that will come of it.

Keyes sums up as follows:

1. When stone complicates enlarged prostate, if the condition of the latter be such that were the stone absent no operation would be called for, then the whole question is to be solved by deciding whether the obstructive quality of the prostatic enlargement, the size of the bar, the depth of the bas-fond, the irritability of the prostatic urethra, and its resentment of instrumental interference,—whether any of these factors be sufficiently accentuated to make litholapaxy impossible or to make it possible only at the expense of leaving the patient (as to his subjective symptoms) worse than before.

If such conditions do obtain, then the stone should be removed by the knife.

2. In short, the main matter is one of diagnosis by the searcher, the cystoscope, rectal touch, and the tentative testing of the prostatic urethra with instruments.

3. The mere size of the prostate is not a factor in the problem.

4. The size or position of the stone is not a factor, except in the case of encysted stone, or one too large for the lithotrite to grasp, or in the case of a foreign body. The smallness alone of the stone is relatively an argument against litholapaxy, since the symptoms in such a condition must be ascribed rather to the prostate than to the foreign body.

5. If lithotomy be performed, the suprapubic route should be elected, since this opens the door for more perfect work and allows the surgeon to remove obstructions, such as third lobe, interstitial growths, outstanding horse-collar enlargement, bar, and to lower the vesicle end of the urethral floor, thus accomplishing all that could be done by a more extensive prostatectomy without very seriously increasing the operative risk.

6. Finally, here, as elsewhere in surgery, the only safe practical guide is surgical judgment, based upon diagnosis, guided by experience.—*Annals of Surgery*.

H. L. NORTHROP, M.D.

THE INTRAUTERINE USE OF THE KOLPEURYNTER.—(Kleinhaus.) Schauat recommends this procedure for the following cases:

1st. Premature rupture of the membranes, complicated with transverse or vertex positions in contracted pelvis.

2d. Prolapse of the navel cord or an upper extremity beside the head, with a narrow cervical canal, after reposition has been effected.

3d. Partial placenta prævia, with hæmorrhage, after premature rupture of the membranes, with weak pains.

Maurer employed the intrauterine use of the kolpeurynter, combined with constant traction, for the dilatation of the cervix, and recommends his method for all cases in which labor needs to be hastened. The cervix must be dilatable for one or two fingers. This method has been used with a considerable degree of success, and has recently been advocated by Müller.

The technique may be briefly described as follows: The patient is placed on the table in the dorsal position; the genital regions are thoroughly

cleansed with water, soap, sublimate and lyssol; narcotics are employed only in cases of eclampsia; the vagina is thoroughly cleansed after distention with the speculum; the os and cervical canal are dilated sufficiently for the introduction of a finger, and the anterior lip of the cervix seized with a bullet forceps, the portio vaginalis rubbed with sublimate, and again sponged off. The kolpeurynter, which has been previously boiled, is rolled on its axis, seized with a long dressing-forceps and introduced into the uterine cavity, and filled with a 1 per cent. solution of lyssol. This pear-shaped rubber balloon, with rather thick walls, and about the size of a child's head when filled, should have connected a rubber tube about 40 centimeters long. In cases requiring the induction of abortion, a smaller balloon is more advantageous, and about 750 cubic centimeters are injected into the balloon with a syringe.

The end of the rubber tube is closed with a stop-cock, the patient put to bed, and the pelvis elevated so that traction can be exercised as much as possible in the pelvic axis, so as to avoid pressure upon the urethra and decubitus. Continual traction can be produced in most cases by hanging a weight on the rubber tubing, or it can be fastened to the foot of the bed.

The writer sums up his article as follows:

1. Dilatation with a rubber balloon is a valuable method of inducing premature labor, as it is more rapid and more certain than the methods commonly used.

2. In pathological alterations of the uterus the method may fail, and complete uterine atony may follow a brief period of uterine activity.

3. In eclampsia, the method is the best which we have for rapid delivery.

4. The method is less to be recommended for the induction of abortion, as the methods in ordinary use require the same amount of preparation, and will accomplish equally well the same object.

5. On account of the disadvantages of the rubber balloon, he recommends those made of inelastic material, especially those of Champetier.—*Monatsschrift für Geburtshilfe und Gynäkologie*, Babd. vii., 1898, Heft. 2.

THE CONSERVATIVE TREATMENT OF CHRONIC INVERSION OF THE UTERUS.—(Kehrer.) The inverted uterus is drawn down to the vaginal introitus in a loop of gauze, and the anterior wall in the region of the os externum is split in the median line through the entire length of the cervix up to the middle of the corpus uteri, and just within the peritoneal fold. By spreading apart the edges of the wound, the fundus, like the finger of a glove, is pushed backwards and upwards from the vagina, and the wound united from the fundus down to the os internum by deep catgut sutures. The reposition of the fundus of the uterus is materially aided by counter-traction, with volsella forceps applied to the os externum. After the uterus has been replaced and the wound united, the cavity of the uterus and the vagina are packed with iodoform gauze. He performed this operation for the first time on the 14th of February, 1898, in a woman who had given birth, for the first time, on the 25th of July, 1897, and had flowed almost continually since that time. The operation was quickly accomplished, and accompanied by very slight bleeding, and produced a firm cicatrix without peritoneal irritation. The patient was



dismissed with a cavity of the uterus 6 centimeters long, the uterus anteflexed and fairly movable, and without any exudation in the cul-de-sac of Douglas. The external os was broad, and will be narrowed by removing a wedge-shaped piece of tissue in the median line.—*Centralblatt für Gynäkologie*, No. 12, 1898.

**TECHNIQUE OF EXTIRPATION OF THE UTERUS.**—(Bumm.) After the abdomen is opened the tumor is raised up as far as possible, and first one and then the other pelvic infundibular ligament is clamped with two forceps and cut between. The same manœuvre is repeated on each side with the broad ligaments, which have been previously unfolded. The space may be ever so small, yet it can always be seized by the fine jaws of the two clamps, and the ligament can be divided close to the metal between the forceps without any fear of their slipping. After the tissues have been separated between the second pair of forceps, the upper margin of the bladder is separated, the peritonæum divided transversely from one ligament to the other, and the bladder carefully stripped off down to the vaginal floor. The ureter is pressed to one side, and the anterior surface of the lower portion of the broad ligament is made visible, with the vascular bundle of uterine arteries, which is seized in a similar manner by a third pair of clamps, and then divided. The uterus is now free at the sides, and hangs only by the vagina, which is easily divided; a fourth pair of clamps seize the lateral portion of the Douglas cul-de-sac, and the uterus is completely removed, with six clamps hanging to it.

The bleeding vessels are now ligated, and the peritonæum united with a running stitch from one side of the pelvis to the other. In myomas developing in the broad ligaments the method of procedure is the same, and the deeper portions of the broad ligament are clamped off after enucleating the nodules of the myoma from the connective tissue.—*Ibid.*, No. 11, 1898.

**SOLUBLE SILVER BOUGIES FOR THE TREATMENT OF CATARRHAL ENDOMETRITIS.**—(Klien.) We have exceedingly good antiseptics which almost amount to specifics in cases of gonorrhœa in Credé's preparation of silver and actol, itriol, and in the soluble silver. The difficulty lay in the preparation of these agents for the treatment of catarrhal endometritis. The writer is no friend of uterine irrigation, especially if it has to be done in an office, and the introduction of medicaments in powder form into the uterine cavity is too difficult for practical application. The ordinary methods of preparing bougies from cocoa butter are defective, in that they are not soluble in water. After numerous experiments he recommends that made from milk-sugar, gum arabic, albumin and glycerine, and wrapped in glazed paper. He gives itriol the preference, as it is readily soluble in water, and even in strong solution is not cauterizing in its effects, as is actol, and he has used it for endometritis in the proportion of two per cent. It has been especially serviceable in gonorrhœal endometritis, and he heartily recommends free use of it.—*Ibid.*

**OVARIAN TRANSPLANTATION.**—(Knauer.) Labor at the normal end of pregnancy, after transplantation of the ovaries in rabbits.

The animals were etherized, and with aseptic precautions the ovaries were extirpated from their normal site and transferred to another portion of the

peritonæum, near the mesometrium, where they were so placed in little pockets in the peritonæum that a portion of the surface remained free in the abdominal cavity. These experiments show :

1st. That in rabbits the ovaries can be transplanted to other places than their normal locations.

2d. That they may be attached either to the peritonæum or to muscular tissue.

3d. That such transplanted ovaries are not only nourished, but also have their functions, *i.e.*, they develop follicles and may bring them to maturity.

Thirteen months after the first operation the abdominal cavity was opened to ascertain the condition of the transplanted ovaries, which were found to be practically normal. The horns of the uterus were well developed, corresponding to the normal pregnant uterus of the animal. There was a broad adhesion in the middle of the right horn with a loop of intestine, which was separated. The implanted ovary in the right mesometrium was nearly normal in size, one pole adherent and the other free in the abdominal cavity, and containing three follicles apparently ripe. The ovary on the opposite side was similar, but contained no follicles. The abdominal walls were closed, with a view to further experiments. In the beginning of December, 1897, conception took place, and on the 3d of January, 1898, two well-developed full-term rabbits were born—one male and the other female.—*Centralblatt für Gynäkologie*, No. 8, 1898.

COMPARISON BETWEEN INDICATION OF PREMATURE LABOR AND SYMPHYSEOTOMY IN CONTRACTED Pelves, WITH DIAMETER OF 8.5 TO 9.5 C.M.—(Audebert.) The mortality of premature labor is very high as regards the children—41 per cent. according to the German, and 35.5 per cent. according to the French statistics. As a matter of fact, the mortality rate is still higher, as it is not always possible to follow the children after they are dismissed from the clinic. Rather than induce premature labor in the above forms of pelvic contractions he recommends waiting until the end of pregnancy, and very frequently until labor occurs either spontaneously or artificially, and the performance of symphyseotomy to save the child—an operation which he believes a safe one for the mother. The maternal mortality of this operation shows, after a careful study of the statistics, .95 per cent. in 314 symphyseotomies, and the mortality of the children is only 9.15 per cent.

All the disadvantages which have been ascribed to the operation are due to faulty technique. He gives statistics of 39 labors from his own cases (of conjugate from 8.5 to 9.5 c.m.). Of these, there were 7 premature labors with no maternal mortality ; 3 fatal cases in the children ; *i.e.*, a mortality of 42.85 per cent. There were 18 spontaneous labors without mortality to mother or child ; 20 labors were terminated artificially ; 3 perforations ; 2 versions ; 14 forceps, without mortality for the mother, and 5 children lost ; *i.e.*, a mortality of 25 per cent. for the children. There were, finally, 4 symphyseotomies without loss of either mother or child.—*Ibid.*, No. 4.

IS CAUTERIZATION WITH A HOT IRON PROTECTION AGAINST INFECTION ? —(Ten Brink.) The writer has made extensive experiments on animals, and in all cases found that inoculation from the superficial surface of the cauterized tissue gave a positive result, the animals being killed on the second, sixth and tenth days, and the slough examined microscopically. Micro-organisms were

found both in superficial and deeper layers, and he concludes that cauterization forms no protection from the penetration of micro-organisms. If this cauterization furnishes no protection against infection with pathogenic micro-organisms, it is improbable that it furnishes any protection against infection with carcinoma, as in the igni-extirpation of carcinomatous tissue by the hot iron. The latter may destroy the cancer-juice in the cut surface, but the cauterized portion may be subsequently infected by it quite as easily as with the staphylococci, which have been found in his experiments.—*Ibid.*, No. 2.

GEORGE R. SOUTHWICK, M.D.

**ASEPSIS OR ANTISEPSIS.**—In an editorial in the *Medical and Surgical Reporter*, April 16, 1898, a letter from Lawson Tait is published, in which he says: He (Dr. T. Gaillard Thomas) puts forward a group of figures which shows that in seven large selected hospitals in America the results of abdominal section run from 25 per cent. in the Boston City Hospital down to 15.03 per cent. in his own institution. Of this collection of statistics I have only two things to say: That the whole thing is deplorable and must be remedied; and that the mortality in the New York Women's Hospital is "murderous," as Mathew Duncan used to put it. He certainly does not make the matter any better by pointing out that during the period of thirteen years the mortality in his hospital has been 22.43 per cent., and that this triumphant result has been due to the introduction of "antiseptic, the sheet-anchor of the surgeon." This makes me more than ever thankful that I discovered the fallacy of this so-called antiseptic craze early in my career.

F. W. BRIERLY, M.D.

**A CASE OF NEURO-RETINITIS HÆMORRHAGICA CURED BY ADMINISTRATION OF IRON.**—Elze, K., of Zwickau (*Woch. f. Therap. u. Hyg. des Auges*, February 10, 1898) reports a case of a girl, aged 17, who had dysmenorrhœa, in whom there was seen by the ophthalmoscope a one-sided neuritis optica, with stroke-like hæmorrhages, in the retina, which must have come on suddenly.

Between the macula and nerve head there was a large white spot of choroidal maceration, which seemed to be the site of a previously-existing hæmorrhage which had been resorbed.

Iodide of potassium and salicylate of soda were given without result. The chlorosis called attention to the necessity of giving iron, which cured this condition, as well as the dysmenorrhœa and the tendency toward neuro-retinitis.

**CATARACT IN GLASS-BLOWERS.**—Hirschberg (*Berl. Klin. Woch.*, February 7, 1898). The ætiological connection between cataract formation and occupations entailing exposure to intense heat, as well as residence in hot climates, has long been recognized. Of thirty men employed as glass-blowers, but five had reached the age of forty, and all of these had developed glass-blower's cataract.

The frequency of cataract in India is well known.

The comparative early age at which this affection develops, as the result of exposure to heat, has never before been dwelt upon; whereas in senile cataract the average age is in the neighborhood of sixty-six years. In glass-blowers' cataract and among the inhabitants of India the average is forty years.



PROTARGOL IN OPTHALMIC PRACTICE.—This new silver-salt contains 8.3 per cent. of silver.

It is a chemical combination of silver with a proteine substance, and forms a yellowish fine powder, which dissolves readily in hot or cold water. Its most important peculiarity, not shared by any other silver-salt, is that from the aqueous solution it is not precipitated by either albumin, diluted chloride of sodium, diluted muriatic acid or caustic soda. These characteristics give this salt as great a facility of penetrating action on the tissues as no other silver-salt enjoys, and causes but an extremely small amount of irritation.

While not trying to praise protargol as a panacea for all conjunctival inflammations, I am so impressed and pleased with its beneficial and almost painless action on the conjunctiva that I want to draw the attention of my *confrères* to it. I have used it in 1 per cent. solution. In this strength it causes no noticeable inconvenience to the patients, who, on that account, greatly prefer it to the silver nitrate.

The writer's information concerning the nature of protargol is derived from an article by Neisser.—Adolf Alt, M.D., St. Louis, Mo., *American Journal of Ophthalmology*, January, 1898.

EYE-STRAIN IN HEADACHES.—Frederick C. Cheney, M.D., of Boston, Mass., alluding to the importance of eye-strain as an ætiological factor in the various forms of functional headache, now so well recognized both by the medical profession and the laity, enumerates the varying peculiarities of such ocular headaches, and the many symptoms of eye-strain in general. He calls especial attention to two conditions, which are not sufficiently known, as being caused by eye-strain—*vertigo* and *drowsiness*.

He mentions the fact that vertigo is produced most frequently by some systemic disorder, but he recites examples in which this symptom depended upon eye-strain, and disappeared after proper glasses had been prescribed.

While he does not credit errors of refraction with being frequent causes of drowsiness, he mentions the fact that such a connection is not uncommon, and relates cases in which such drowsiness, especially upon application to near work, was removed by correcting lenses. Examples are also added showing that in some cases, at least, "that tired feeling" with which so many are afflicted is dependent upon eye-strain.—*Boston Med. and Surg. Jour.*, February 17, 1898.

DEAFNESS.—Dr. Gorham Bacon, of New York, reports the case of a male patient of 33 years who, when first seen, had both tympanic membranes destroyed and the ossicles bound down by adhesions. There was a slight discharge from the ears. Under the hypodermic injection of pilocarpine the patient, who had formerly been able to hear only by means of a trumpet, could now hear the raised voice at a distance of one and a half feet. The remnants of the drum-head and ossicles were then removed, this being followed by greater improvement in the hearing.

The author has obtained the best results from pilocarpine in cases of sudden deafness due to syphilis.—*New York Medical Journal*.

WILLIAM SPENCER, M.D.

## MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND  
THERAPEUTICS.

A VALUABLE ADDITION TO THE MATERIA MEDICA.—Dr. W. W. Winthrop, of Fort Worth, Florida, in the *Texas Record*, gives his experience with a plant found in the Everglades of Florida and called by the Indians "husa." The plant, as yet unclassified, is of a dirty whitish-green color, with a ball-like formation at its summit where the flower should be, slightly lobulated, and to all appearances like a small cauliflower. It grows in clumps in moist, shady places, particularly on hummocks at the root of the cabbage palms. It is of a low order of plants, above the mosses, probably a cryptogam and indigenous to the everglades. It is claimed by the natives that the plant is a perfect antidote for all snake-bites and stings of insects. A negro in the presence of Dr. Winthrop allowed himself to be bitten several times by moccasins freshly caught, whose poison is ranked among the most virulent of snake-poisons. After each bite he chewed a little of the herb, which he said counteracted the venom. This was probably true, as no bad effects followed the bite.

Dr. Winthrop, in subjecting the plant to the strongest tests, finds it one of the most diffusible stimulants, acting immediately. He and other physicians who have joined in the tests find the plant not only a perfect antidote for narcotic poisons, but an infallible cure for the opium habit. He says it takes the place of opium, sedative but not narcotic, supporting the patient fully. It produces slight elation, but no somnolent effect. A physician cured himself of the opium habit with it. He said that the effect was delightful, making him feel as comfortable as one would feel after a satisfying meal. Several physicians who have tested the drug in the opium habit declare it a perfect success. Dr. Winthrop is a man of high standing in his profession, and his testimony seems so positive as to exclude doubt. The field of action of a diffusible stimulant is so vast that when thoroughly tested this drug may prove one of the most valuable remedial agents in the materia medica.—*Medical Times*, May, 1898.

LYCOPUS IN EXOPHTHALMIC GOITRE.—The treatment of exophthalmic goitre has been so unsuccessful in the hands of the old school, and so little is said of it in our own journals, that Halbert considers it well to call attention to lycopus again. Some years ago he took the ground that exophthalmic goitre was a disease of the sympathetic, and attributed the three cardinal symptoms, exophthalmus, tachycardia and goitre, to a paresis of the sympathetic cervical ganglia, and a general vaso-motor derangement from a progressive involvement of the whole sympathetic system. Since that time experience has confirmed him in his theory, notwithstanding the many more re-

cent deductions. The whole picture of the disease, from the time of its inception to its extreme culmination, points to that pathological condition. The cure, therefore, must come from some remedy that has simulating symptoms, and these we find in the provings of *lycopus*. Excision of the cervical ganglia will not cure it, because the disease is not permanently there.

The author reports with some detail a case in which *lycopus* proved successful, and refers to several others in which the results have been equally satisfactory.—*The Clinique*, April 15, 1898.

(The records of a number of cases in the Neurological Department of Hahnemann Hospital, Philadelphia, show conclusively the value of *lycopus* in this disease.—ED.)

**THE SYMPTOMATOLOGY OF ANTIPYRINE.**—*General Action.*—Reduces the temperature very rapidly. Allays pain. Alters the shape of the red blood-corpuscles. Separates and decomposes the hæmatin. Leaves a depressant influence on the brain. Diminishes the oxidation. Acts as a heart tonic. Fills the capillaries.

*Mind—Anxiety.*—Loss of memory. Loss of consciousness. Feels drowsy, or rarely exhilarated. Peevish and irritable. Talks in a jerky manner. All motions are made in the same way.

*Sensorium.*—Numbness. Snapping sensation in the head, nearly driving crazy. Prostration and dizziness. Vertigo. Feels as if intoxicated. Sensation as if the inside of the body were filled with ice.

*Headache.*—Great migraine. Pain in the frontal sinuses.

*Eye.*—Closed on account of the erythematous swelling. Dimness of vision. Pupils dilated. Suffused, with great congestion. Catarrhal congestion, with great swellings of the lids. Ephemeral amaurosis.

*Ears.*—Ringing in the ear, with much congestion. Buzzing sensation.

*Nose.*—Violent and long-continued sneezing. Coryza. Irritation of nasal fossæ. Coppery smell, which is not constant, but comes and goes.

*Mouth.*—Itching and burning of the mouth, especially on the roof. Coppery taste, which is not constant but comes and goes.

*Throat.*—Itching and burning. Hoarseness. Cough, with or without expectoration. Tight constricted feeling. Loss of voice. Swelling of lining of mucous membrane, giving sensation of suffocation.

*Appetite.*—Anorexia. Thirsty only in A.M. on rising.

*Stomach.*—Vomiting. Epigastric pain, causing to bend double and cry out. Gastro-enteritis. Expanding sensation rising from the stomach. Nausea, with or without vomiting. Burning sensation in the pharynx.

*Urine.*—Incontinence of urine. Amount is diminished. Great excess of nitrogen, as in typhoid fever.

*Chest.*—Pain and tightness of chest. Dyspnœa. Tumor-like sensation over the notch of the sternum, with slight dyspnœa. Breathing hard and labored; can't lie down on this account.

*Pulse.*—Rapid and full. Goes up and down with the temperature.

*Buck and Limbs.*—Limbs swollen. Œdema of arms and hands. Pains in the shoulders, running into arms and neck. Pains in the groins, running down the inside of the thighs. Pain from the cardiac region to the left shoulder. Great coldness of the feet, without collapse. Great pain in all the limbs.



*Skin*.—Profuse sweating. Cyanosis. Erythema, beginning in the arms and running down. Urticaria, especially on the inside of the thigh. Swelling of the face and hands. Livid color of the face.

*Fever*.—Intermittent sensations of cold. Cold sweat. Quick rising in temperature with the chill. High fever in the morning on rising.—*The Hahnemann Advocate*, May 15, 1898.

**CHELIDONIUM IN CANCER.**—A writer in the *Homœopathic World* quotes from a Russian authority with reference to the remarkable value of *Chelidonium* in the treatment of cancer, whether the growth be external or internal, and side by side with this report describes the external appearance of the great Johannas Bram who recently died from cancer. He says that when the first signs of his serious illness appeared last year he turned yellow and then brownish, and his strong frame shrank visibly from month to month. It was the talk of all classes. In conjunction with these two reports he quotes from the proving of *Chelidonium* the following: whites of the eyes dirty yellow: face grayish-yellow, sallow sunken yellow, especially forehead, nose and cheek. Tongue coated thickly yellow; skin yellow, *yellowish-grey*, especially adapted to spare subjects, disposed to abdominal plethora. Who that has seen a true case of cancer has failed to be struck with the *yellow-grey* complexion. The above is, to say the least, suggestive of a possible homœopathic cure for this direst of diseases.—*The Hahnemann Advocate*.

**BORAX IN LEUCORRŒA.**—Dr. Wilson A. Smith, in the *American Homœopathist*, reports a case that is diagnosed as areolar hyperplasia and ulceration of the cervix. An examination presented a red inflamed mucous membrane partly covered with a secretion resembling the white of an egg. She said it made her sore, and that she was worse before and after the menstrual period. It was accompanied with a sensation as of a hot fluid running down the thighs, and she complained of a *sticking pain in the clitoris at night*. The menses were too soon and too profuse, although she never thought of them as being like a flooding. She was exhausted during the flow. The guiding symptoms in this case was the *stitch in the clitoris*—characteristic of borax. Upon searching, all the other symptoms were found under this drug, and she was cured with but five powders of the medicine.

It would be interesting to know whether *borax* had been a prominent constituent in the douches employed in former treatment of this case, and it would also be interesting to note whether the character of the leucorrhœal discharge was changed under the action of *borax*, or *boracic acid*, from that which first called for its use. In other words, whether the *borax* failed to cure the cause for the original leucorrhœa because it was not indicated, and because of its persistent use constituted a *drug disease* of itself, and of course could not be cured while it was being employed. The question of catarrhal discharges or discharges in general constitutes a very interesting phase in the study of medicine and should receive greater consideration than it has in the past.

**STRYCHNINE POISONING.**—Dr. A. Huber reports that two hours after intestinal ingestion of this drug he thoroughly washed out the stomach, gave strong coffee and ten drops of tincture of iodine every two hours. Later he

administered seventy-five grains of potassium bromide. Recovery followed. The notable conditions, aside from the usual symptoms, were in this instance the elevation of temperature on the first day, the retention of urine, and the appearance of blood and casts in it. The first is explained by the enormous activity of the muscles; the urinary retention by the spasm of the sphincter vesicæ. The blood and casts can be explained by the irritation which strychnine in large doses produces in the kidney. During convalescence the influence of strychnine upon metabolism was marked in that the chlorides and phosphates were markedly diminished at the commencement, but increased daily in amount, while the urea remained constant as in normal urine.

**SOME EFFECTS OF CANNABIS INDICA IN LARGE DOSE.**—D. Robert C. Bicknell regards as worthy of note the existence of muscular contraction, followed later by convulsive movements, evidently due to action of the drug on the spinal cord. Aside from acceleration of the pulse-rate and a feeling of fullness in the artery at the wrist, there was, just previous to the occurrence of unconsciousness, a sense of extreme tension in the abdominal blood-vessels; they felt distended almost to bursting. After some hours the urine was markedly increased in quantity. No constipation resulted. There was no foreboding nor fear of impending death.

**PARTIAL PROVING OF EUONYMUS.**—The drug was prepared from the fresh wahoo root, dug in Washtenaw County, Michigan. The subject was a male, twenty-four years old, of nervous temperament, strictly temperate, did not use tea, coffee, tobacco, always ate plain food; healthy; had no idea of the nature of the drug he was taking; was required to report whenever anything that seemed a symptom developed. Began with a drop of the tincture, the dilution being changed from time to time until the fourth was given. Time of taking medicine, three weeks every two hours every day. Some of the most prominent symptoms were developed after discontinuing the drug. The notes are in the prover's own words: "Felt elegantly for about a week, then began to feel tired generally. Bowels a little lax. Have had to 'brace up' to keep a-going. Sleep not good. Restless first part of night, wake up early in morning. Pain over the liver. Pain in right lung. Was accused of being drunk on the street. Stomach feels 'off' with nausea and flatulence. Worse evenings. Headache over and around eyes. Heart has been sensitive. Palpitation when running up and down stairs. Did not go to sleep for two hours. Was restless, could not sleep. Have been so thick-headed for a week that could not study. Slow in getting senses together. Have to think and think to answer a simple question. Some days after stopping medicine thought liver was enlarged; had that sensation. Region of liver was tender." (Note by observer: One night came to house and called me up; he was alarmed because of the sensations just given. Was sure he had "some liver disease." This is significant, for the prover had had no suggestions as to what symptoms he might experience or what the drug might be like in its action.) "Belched gas in small quantities with the flatulence not relieved. Was constipated for some time after the second day of stopping. Was not able to study for two weeks after stopping the medicine."—*The American Homœopathist*, June 1, 1898.

F. MORTIMER LAWRENCE, M.D.

# THE HAHNEMANNIAN MONTHLY.

---

AUGUST, 1898.

---

## PERITONITIS.

BY O. S. RUNNELS, A.M., M.D., INDIANAPOLIS.

(Read before the Indiana Institute of Homœopathy, at Indianapolis, May 25, 1898.)

DOWN to very recent times the diagnosis "inflammation of the bowels" represented the sum of knowledge concerning acute abdominal diseases. It was an index of ignorance rather than of knowledge, inasmuch as it gave no definition of the exact tissues involved, and no intimation or suggestion as to the ætiology. The discovery that the disease in question was almost invariably an inflammation of the peritonæum marked a great advance, and led to more intelligent study of causation. The acquisition of this knowledge was greatly facilitated by the lessons taught in abdominal surgery.

Until surgeons began to make open exploration of the peritoneal cavity the density of ignorance concerning the ætiology of peritonitis was not greatly lessened, and not till surgery had been rendered aseptic was our knowledge upon the subject lucid. When the frightful mortality attendant upon abdominal surgery in its early days was proven to be almost entirely avoidable by a faultless and aseptic technique, the evidence was conclusive that surgical peritonitis, at least, was a germ disease.



From this solution the inference was legitimate and the proof forthcoming that idiopathic peritonitis also was a germ disease and dependent upon filth-contaminations. Laboratory experiment was thus reinforced by clinical experience, until the proposition was universally accepted that the exciting cause of peritonitis was invariably disease-producing bacteria in the peritoneal cavity.

The force of this deduction has not been lessened by the recognition of the part played by predisposing causes; that some peritonæums are more susceptible to sepsis than others, and that numberless instances of successful resistance to the imposition of micro-organisms, are in evidence. This leads, however, into the discussion of the question of the normal life-resistance, and the ability of nature to prove itself invulnerable under certain contingencies, *i.e.*, when endowed with its full complement of vital energy; but this is not within the scope of this paper, and its mere mention must suffice.

Given, then, an inflammation of the peritonæum, what are the avenues of infection, what are the evidences of its presence, and what are the modes of treatment?

*Ætiology.*—It is a question in each instance of accounting for the causative bacterium. By what avenue is the peritoneal cavity invaded? How do schizomycetes gain entrance? Comprehensive answer to this must be made that it is always from without. That these micro-organisms are never generated *de novo* from within the peritoneal sac, but are always immigrants from regions external to that enclosure. Under normal conditions you may search in vain for any evidences of germs upon the peritoneal serosa. Such a presence is invariably indicative of morbid conditions and denotes infection.

It will be recalled that the peritonæum in the male is a sac without an opening, while in the female there are two openings, *viz.*, at the fimbrial extremities of the Fallopian tubes. Aside from these anatomical orifices, there are no normal entrances to the peritoneal cavity. The germ-invader, therefore, is restricted to four modes of entrance:

(a) Through the ostia of the Fallopian tubes—restricted to the female;

(b) Through perforations of the peritoneal membrane occa-

sioned by abscesses in contiguous regions, or by intestinal ulcerations;

(c) By way of transmigration through devitalized but unbroken tissues; and

(d) Through artificial openings made by the surgeon in pelvic or abdominal section.

Bacteria may take advantage of any one of these entrances as opportunity may offer, or they may utilize two or more of them at the same time.

Idiopathic inflammations in the female pelvis owe their existence to a septic endometrium. They are invariably dependent upon microbic migrations from the septic uterine cavity through tubes or adjacent tissues to the inflammatory centre. The rule is that the infection is communicated through the fimbrial extremities of the tubes, but exceptions are frequent where the bacteria have elected to take routes more direct. Owing to broken continuity of cervix or endometrium, or to morbid processes which may lower the tone and in a measure devitalize the surrounding tissues, the emissaries of sepsis may proceed "across lots," as it were, through the intervening tissues and by the way of the lymphatics to the site finally selected by nature for the contest. In cases, therefore, where pelvic inflammations exist without tubal contaminations, they are dependent upon infection conveyed by way of the lymphatics to broad ligament and subperitoneal tissues.

These cases are of the order that may terminate in peritonitis through perforations of the peritonæum resultant from abscess or ulceration. Of like character, though of different origin, is the extra-peritoneal phlegmon in other localities that may have final relationship to peritonitis. From some source infection is imposed upon the tissues involved followed by inflammation and a pus sac. Even if there should not be an evacuation of this pus into the peritoneal area, the devitalization of tissues by the morbid process may be such as to permit the migration of bacteria through the tissues till the serosa of the peritonæum is reached, the normal local integrity being so far reduced as to offer no bar to the invasion. This is the mode of infection in all cases of intestinal strangulation, as hernia, intussusception, volvulus, etc., resultant in peritonitis.

Open communications with the peritonæum by way of intes-

tinal perforations are by no means infrequent. Ulcerations due to typhoid fever or to confined excreta in the appendix vermiformis may terminate in a solution of peritoneal continuity, thus leading to peritonitis either localized or general. In appendicular peritonitis and tubal infections nature is frequently able to hedge against and circumscribe the invasions by adhesions and abscess formations; but in all low states of vitality—as after dothenteria—nature is rarely able to make successful protest; the invasion is general, the inflammation fulminant or explosive, and the course of it to a fatal termination a matter only of hours. This is especially the case where the infection is communicated by way of *cœliotomy* or vaginal section. The peritoneal resistance being lowered by the exposure, the rough or too long-continued handling of the peritonæum during surgical operation, or by the devitalization of the morbid process, the protest against the imposition of sepsis is too feeble to be effective, and wide-spread infection and grave peritonitis may be the result. Inasmuch, therefore, as all morbid process is to some degree devitalizing, and inasmuch as shock and depression is a marked concomitant of peritoneal surgery, it follows that all surgical intervention should be as clean as a sterilized technique can make it.

There remains one other consideration of peritoneal invasion which is in some respects unique—I mean the invasion by the tubercle bacilli. The implantation of tubercular bacilli upon the peritoneal serosa without any open or measurable source of contamination was for a long time puzzling to the germ theorists. How tubercular peritonitis could develop without manifest morbidity of Fallopian tubes or appendix, and without the local devitalization incident to strangulation, was the unanswered question. This was settled by the discovery that tubercular bacilli—in bodies already so far reduced in general vitality as to make for them a habitat—had the power of migration from organ to organ at will. It has been proven that tubercular bacilli have passed through apparently healthy tissues on their way to some less strongly fortified region without leaving traces of their passage; but in every such event of bacillary aggregation in some weakest region of the body, the general vitality of the physical economy is low and the resistance inadequate.



*Symptomatology.*—The symptomatology of peritonitis is many-sided. No lesion of the body can present as many phases of expression as peritonitis. None can show symptoms more sudden and appalling or more insidious and contradictory. Its evolution in some of its forms may be made without pain or the presentation of any symptoms of abdominal disease. The abdomen may be flat or distended, tympanitic or ascitic, while the temperature may be elevated, normal or subnormal. In certain cases there may be in the early stages little to direct the attention to the real seat of the malady, the diagnosis being made almost wholly by exclusion. Ordinarily, however, the data are unmistakably indicative. The history of the case, the inception of the malady, together with the evidences of its progress, are such as to lead the careful student to definite conclusions. He may not by the reading of the symptoms alone be able to determine the exact ætiology without an open exploration, but he can make apparent the probable necessity of surgical exploration in every doubtful and unyielding case.

It will be impossible in the limit of time here granted to delineate the multiform expressions of peritonitis, or do more than outline some of its general characteristics. Every ailment of the abdominal cavity may have relationship to the peritonæum; so vast is its extent and so intimate and inclusive its relationship that it is almost of necessity a part of every abdominal problem. Peritonitis, either acute or chronic, stands at the very head of the list of probabilities in all abdominal complaints and is the first number for exclusion in every diagnosis of abdominal or pelvic disease. Since it may run its course to a fatal termination in a few hours, or merge into a state of chronicity, either of which may demand surgical intervention, the necessity for recognition at the beginning is very great. It must be remembered that the ordinary expressions of inflammation—chill, fever, pain and tumefaction—may be inconstant, variable or entirely absent when the serosæ are involved. The painless and almost uneventful effusions of the pleura sometimes encountered are typical of possible happenings with the peritonæum. These are serum-tissues, and are endowed with peculiar and extraordinary abilities. The rapid production and collection of serum in the peritoneal cavity when abnormally stimulated may explain to some extent the

vagueness and uncertainty frequently encountered in peritonitis. But while there is wide variety in the expressions of peritonitis, both acute and chronic, there are some symptoms in addition to those usually present that are pathognomonic.

All development of abnormal temperature after surgical intervention is to be regarded as proof of sepsis. This fact is of double importance after all surgery implicating the peritonæum. Any thermal rise above two degrees, particularly if persistent, is evidence of inflammation either without or within the peritoneal cavity. If it be extra-peritoneal, there will be the history merely of simple abscess. When, however, tympanitis supervenes, with persistent vomiting of greenish fluid growing ever darker; when the pulse-tracing indicates a sharp upward curve with continued upward tendency, usually out of proportion to the thermal curve; when the intestines show paralysis and bowel-movement is unattainable or attained with great difficulty; when restlessness is great, accompanied or not by insomnia, the face being drawn or pinched into an expression of deep anxiety and apprehension—I say when signs like these obtain the inflammation is intra-peritoneal, and a question only of degree.

In cases of the utmost gravity an opposite tabulation of facts may be encountered. There may be absence of pain or special tenderness, or tympanitis; the temperature may remain but slightly elevated or may be even subnormal, while the pulse may be weak and slow, or, if high, easily compressible and perhaps intermittent; the stomach but little disturbed, the fluid vomited small in quantity but greenish, and the bowel-movements frequent and profuse. These cases indicate profound depression of the vital forces and lack all the evidences of vigorous protest against the septic imposition. Desire for food or the toleration of it is incompatible with acute general peritonitis, and the patient always feels "very sick."

In non-surgical peritonitis, while the same symptoms may be presented, there is usually a history of more or less prolonged congestion or inflammation in some particular locality within or adjacent to the peritonæum. The symptoms are at first localized, and ordinarily at the seat of the difficulty. Exceptions to this rule, however, are to be noted, as in appendicitis, where the pain may begin on the opposite side of the

abdomen or in any part of the peritoneal cavity, due to a dislocated or abnormally long appendix. Remembering that non-surgical peritonitis is resultant from infection communicated through peritoneal orifices, or through openings produced by erosion or ulceration, or through portions of peritonæum devitalized by interrupted blood-flow to a given point, we are prepared to make readier estimate of all secondary phenomena implicating or liable to implicate the peritonæum.

But however astute the diagnostician, and however ready the patient may be to aid in the elucidation of his problem, the testimony may be so vague and contradictory as to be very confusing. In fact an accurate diagnosis may not be possible without an open exploration of the peritoneal cavity. A good illustration of the difficulties sometimes encountered by the diagnostician, and of the necessity of a very early exploratory incision and possible operation in all doubtful abdominal cases, is shown by one of my recent experiences :

Mrs. N., age 60, weighing 200 pounds, had a history free from all manifestations of disease. Prior to her fatal illness she had had unbroken health. Three weeks before her death she experienced a light chill, followed by a slight degree of fever and some abdominal tenderness in the ilio-cæcal region, which her physician diagnosed as "typho-malaria." There was at no time during the course of her case, from first to last, over two degrees of abnormal temperature, and the pulse was less than one hundred. The bowels were constipated, there was a fair degree of appetite, but she had perhaps once a day or once in two days an attack of vomiting. The tongue was slightly furred, with increasing tendency to dryness, which assumed the typhoid appearance in the later stages. Being called into the case at the end of the first week I diagnosed appendicitis. There was decided tenderness in the region of McBurney's point, with but little evidence of tumefaction. Under expectant treatment for a few days the tenderness was lessened, and there was manifest improvement in her other symptoms, but no convalescence. Owing to the presence of a very heavy deposit of adipose tissue upon her abdominal walls, and to the fact that the symptoms were not urgent, I hesitated to advise cœliotomy. At the end of a week, however, I attempted the operation for appendicitis. Cutting through her four-inch wall



at the point named, I entered a pus-cavity containing perhaps a gill of pus and four large gall-stones, weighing 437 grains, collectively. It was a case originally of empyema of the gall-bladder resulting in rupture of that viscus. The extrusion of the calculi and septic matter of the gall-bladder into the peritoneal cavity instituted local peritonitis. The stones gravitated to the appendix region, where they were found in the pus collection. The appendix was normal and was not interfered with. Having a ruptured gall-bladder and wide-spread infection already established, her cure was impossible. Her steady decline seemed to be in nowise accelerated by the intervention, and she died four days later.

The case was unique in that there was no previous intimation of biliary calculi, and no symptom of icterus or other manifestation of hepatic complications. The sequel proved that the diagnosis of this case without exploratory incision was impossible, and that no method of treatment could have succeeded after the erosion and destruction of a large portion of the wall of the gall-bladder precedent to the rupture. Cholecystotomy before the occurrence of that event offered the only means of cure.

This incident reinforces the demand for very early exploration of the peritoneal cavity in all cases of abdominal doubt. The proofs are cumulative that only in early recognition of the true status is cure possible in a vast number of cases, and that knowledge of that status may not be attainable except by visual examination of the intra-peritoneal condition.

*Treatment.*—The treatment for peritonitis is voluminous. So multiform is the expression of it, and so full of danger is the nature of it, that every resource of the physician and surgeon may be taxed to the utmost in combating it. There can be no stereotyped line of treatment applicable alike to all cases. It may be from beginning to end a purely medical case; it may be from the beginning a purely surgical case, or it may be medical and surgical conjointly. It is certain that all who make a fad of a single line of treatment in peritonitis will have a longer death-roll than is warranted. The doctor for peritonitis especially must be a man capable of putting to service, in every possible contingency that may confront him, all that may be called for in the conduct of the case. He must know how

and when to depend alone upon the dynamis of drugs, and he must know how and when to employ the resources of surgery; for the one may be just as important as the other in a given case, and neither perhaps wholly dispensable in any case. Certainly in the present state of science no one can properly treat a case of peritonitis without the utilization of surgical knowledge, for no one can predetermine what moment the case may assume a surgical aspect and require manual intervention. This is especially the case in all instances of appendix complications. The claim is not made that every case of appendicitis should have immediate surgical treatment, but that any case of appendicitis may at any time require it.

Under expectant treatment many cases of appendicitis are conducted safely to convalescence, but it is a question always as to the limitations of expectancy. Recurrence is to be looked for in every surviving case, and the recovery from appendicitis without removal of the appendix in nowise establishes the unwisdom of such a procedure. Each recurrence of appendicitis points unerringly to the necessity of removal. If a period of quiescence can be chosen for the employment of the surgical remedy it is especially fortunate, inasmuch as the danger from sepsis in the presence of established inflammation is greatly enhanced and the danger from operation in the interim is practically nil.

If the extraction can be made before perforation occurs, and before sepsis in gross amount has been imposed upon the peritonæum, the surgical choice is realized. The best interests of the patient demand that surgical aid be extended before the arrival of that event. The attempt to save life after the occurrence of that misfortune is perilous indeed under any *régime*, and in the majority of instances hopeless. It is unfair to charge the death to surgery when the circumstances are thus forbidding. Every advance in experience emphasizes an earlier and more general employment of surgery in appendicitis. Considering the dangers of delay and the possibilities of erroneous diagnosis in the unexplored case—especially in view of the invariable ætiology—the demand is increasing for radical treatment from the start.

For all chronic manifestations of peritoneal embarrassment the question as to the right course of procedure is not mooted.

The possibility of tubercular complications must be borne in mind at all times. Surgical intervention for tubercular peritonitis is the only treatment admissible. There is here no choice of remedy and no excuse for delay. The one chance for life lies in the possibilities of the surgical invasion of the peritoneal cavity. Even if nothing more is done than to explore the cavity, irrigate it, and reseal it, a cure may be secured otherwise wholly unattainable. The discovery and removal of morbid processes which may have originated the tubercular habitat will all the more certainly contribute to the consummation of the cure.

The scope and ability of therapeutic treatment in peritonitis is a part of this discussion of utmost moment. When it shall be employed, how long it shall be adhered to, and what may or may not be accomplished by it, are questions of great concern. While the answers to these questions have been generally outlined in the preceding pages, their more specific consideration is demanded. Employment of medical and adjuvant treatment must have first place, in point of time, in the management of every case. While the diagnosis is being made—a matter always involving more or less time—and while the proper surgical treatment may be under arrest awaiting the decision for or against it by the patient or his advisers, the possibilities of relief from medication should be put to the utmost utility. In many instances the decision as to the course of procedure is a balancing of probabilities requiring the finest discriminations of judgment, and then, even in the present advanced state of our knowledge, the liability to error in certain obscure cases is manifest. The reluctance on the part of the adviser to force the issue when manual intervention is called for, and the universal disposition of the advised to hesitate and demur, leads in many instances to the loss of the golden moment.

Open bowels should be assured at the earliest time possible in every case. The presence of intestinal obstruction should be disproved at the beginning. Rapid and thorough serum-drainage from the alimentary canal by catharsis is of the greatest importance in all peritoneal complications. The saline cathartic, followed in possible appendix cases by the olive-oil cathartic, is of inestimable service in securing riddance of irritating and provoking faecal elements. At the same time, exhibition of the



drug called for by the totality of the symptoms should be made and persisted in faithfully as long as improvement is manifest or attainable. How much can be accomplished under these circumstances by the administration of medicines chosen in accordance with the law of similars it is impossible to estimate, but certain it is that many cases that would have evolved into irremediable peritonitis by the exhibition of anodynes and blunderbuss prescriptions have been safely and speedily restored to health through the faithful employment of the homœopathic remedy.

Reasonably safe rules for guidance may be formulated as follows: So long as the diagnosis is not in question; so long as emergency symptoms are in abeyance; so long as the evolution is favorable to resolution, so long may medication be put to the test.

But whenever doubt remains as to the diagnosis; whenever improvement is not manifest in the space of a few hours in the cases of explosive type; whenever there are proofs of pus within; whenever appendicitis becomes recurrent, or whenever chronic nondescript conditions involve the peritonæum with or without marked evidences of thermal perturbations, the surgical remedy is called for, and its employment should not be delayed.

---

### A PEN-PICTURE OF A PATIENT AT BAD NAUHEIM—A GLIMPSE “BEFORE” AND “AFTER” TAKING.

BY EDWARD R. SNADER, M.D., PHILADELPHIA, PA.

#### BEFORE.

DURING a stay at Bad Nauheim I had the opportunity of “looking on” at the treatment given a fellow-countryman. Bad Nauheim, as you are doubtless aware, is, or is becoming, famed the world over for its peculiar treatment of cardiac disorders. My friend, or one who became my friend while at the Bad, was from the “Windy City,” Chicago, and had been sent on a European tour for his health, and, while on a wild-goose chase after the goddess Hygeia, stumbled on an Englishman on a train, who suggested that Bad Nauheim was “bloom-

ing good, don't yer know, for fat old boys like you, you know." The home diagnosis framed for the patient had been "glycosuria and adiposis prodigiosus."

The "fat man" cottoned to me, to use a vulgar term, at the hotel the first day of his arrival, when he heard me order in beastly, broken German, "Bitte, eine katufel salade, un eine cupf koffee." He knew by my carefully-articulated accent and air of superb correctness that I was simply ordering something that I thought I could pronounce the words of, rather than what I actually wanted. His diagnosis was correct. With the breeziness of his native city he made himself known.

My newly-found friend was about five feet five inches in height, and to the casual observer at twenty feet distance the picture of health. He was stout—too stout, to be sure—for his height and width in the world, tipping the scales somewhere between 175 and 200 avoirdupois, not Troy—not much weight, it is true, but much too much for him. He would strike a doctor at once as carrying too much extra weight, as being too high in flesh, for a long race. His weight for years, when in perfect health, with a fair covering for his small bones, was 112 pounds. (He had not weighed since he left America.) His bones were small, his skin smooth, not dry, his complexion just bordering on the ruddy, his abdomen of such proportions that he possessed without question the most distinguished qualification required of an American alderman; his thighs were like a ballet girl's, his calves of the kind that a boy draws in chalk on the fence after he has seen the elephant at the circus and rudely attempts a reproduction—in other words, indicating strength and size, rather than grace and elegance of outline; those calves were certainly not "trim," and his ankles are not to be mentioned; his chest was big and deep, suggesting, even when dressed, a too big bust development for one of a sex not called into requisition in the lacteal alimentation of the rising generation. His neck was short and thick. He was lethargic, lazy, and yet with all that he was originally of the type of nervous, quick-acting American, now, however, owing to calamities of ill health making serious inroads on his constitution's capital, doing business at the old stand, "limited."

A closer observation revealed that his lips were slightly cyanotic, and that his respirations when quiet were about

twenty-four to the minute. He appeared about forty-five years of age. His occupation was that of a confidential clerk, extremely sedentary. He had taken a course in medicine some years before, but had abandoned it for reasons not stated. He knew just enough to make trouble for his physician. He had bicycled some, in the evenings, but was usually too tired to do anything but lounge. He had been tired for four years, and was more so now than ever. His head was thick and cloudy, and his mental aptitude seemed lost, although by a great struggle he could force himself to mental work, but such exertion was becoming daily more irksome. He had grown very short of breath lately; a slight ascent compelled him to stop, not only from oppression, but occasionally from palpitation of the heart. He did not drink, although he confessed to a weakness for wine at dinner, because he felt heavy and sleepy after it. Whiskey, although not of the Jersey lightning type, nauseated him, even the odor being unbearable. Beer constipated him, and soon "snowed him under." He was, therefore, perforce, a temperance man. He smoked like a steam-engine whenever he got the chance, averaging from fifteen to twenty cigars a day, until lately, when he had succeeded in getting down to ten per diem. He was, unless under special orders of his physician, a good feeder, only seldom suffering from over-eating, the consequences then being a wind-storm, terminating in colic and diarrhœa, leaving him all right, so far as his digestion was concerned, in a day or two. He had never taken any physical exercise in his life until he had tried the bicycle. He lived a regular life—had to; he had lost sexual power, and did not seem worried about its return. The bowels were moved twice or three times daily; soft, not diarrhœic unless from digestive causes, or constipated from beer. For over four years he had personally, as well as his physician occasionally, made observations of his urine. He passed about a quart in twenty-four hours, seldom more. The water always contained sugar in amounts varying from 4 per cent. to less than 1 per cent., the latter on a strictly diabetic diet. His doctor had told him that there was over 5 per cent. urea and an enormous amount of lithic acid in all the twenty-four-hour collections examined, but no albumin at any time, nor casts.

Weakness, loss of appetite and unconquerable irritability of



temper led to his abandonment of a strict diet on his own responsibility. He had see-sawed between the diets. He had lost no flesh; in fact, seemed to be taking on more all the time. His scrotum itched, but he had no dryness of the skin generally—perspired easily, in fact. There was no extraordinary thirst. Sleep fair, sometimes being disturbed by jerking of the limbs—a starting suddenly just as he seemed safe in the arms of Morpheus. He had tried, or he said his physician had tried, except the opium treatment, all known methods of controlling the excretion of sugar. He had felt lately as if something must surely be done, or he was a “goner.” His principal complaints were his lack of energy, his dyspnœa, his glycosuria.

He had had “muscular rheumatism” in various parts of the body at various times, and about two years ago a general body stiffness all over, with localized swellings about the joints, but not located in them, the lumps being a faint red, painful on pressure, but feeling like tumors beneath the examining finger, appearing, too, mostly near the feet, the knees, the hands. This attack was diagnosed “dry arthritis.” His joints “creaked” even now. This fat man, I would have you understand, notwithstanding his half-medical knowledge, was by no means a hypochondriac. I have never seen a man display more “horse sense” about himself. This fact was particularly noticeable when he would, as he occasionally did, take “account of stock” so far as his health was concerned. This procedure was accomplished with as much cool indifference as if he were adding up a column of figures. He simply wanted to know on which side the balance stood, for or against him. He accepted either result philosophically.

His pulse was at 90 or 100 and weak nearly all the time, even when at rest, although there were times when, if he forced himself to make considerable exertion, the pulse seemed to become stronger and not much increased in number per minute. In the morning before rising his pulse was weak, sometimes scarcely feelable, with fits of irregularity and intermittence, averaging between 85 and 95, no counts being exactly alike if the observations were taken on the quarter second or a few moments apart—in other words, irregular as to time and rhythm. Here, then, is the picture of the patient “before.”

He had already made his selection of a physician from the

Union list that hangs in the hallways of all the prominent hotels and villas in Bad Nauheim, and begged me to show him the way to the distinguished practitioner's office. It was the afternoon "sprech-stunde," from 3 to 5 o'clock, when we arrived. A blonde German girl appeared with a list of names, and he inscribed his cognomen opposite the No. 20, and in return for his bit of chirography was given a square piece of tin with the cabalistic 20 rudely punched thereon. All around the garden, in the parlor and reception-room, sat people of all nationalities, the long proboscis of the Hebrew predominating, with similar tin tags on their persons. In a remarkably brief space of time "Numero swanzig" was called out in a rich contralto by the golden-haired German girl, maitre of ceremonies extraordinaria. My friend was ushered into the consulting-room, and in three minutes and a quarter, Greenwich time, he was with me again, and not he alone, but the diagnosis, "Dilated heart; gout." He had a prescription, too, and it was not for drugs, either.

My tyro in matters medical told me that the great man, once he was within the sanctum sanctorum, tapped him above the belt in a percussing way and ausculted him in a lightning fashion with an ivory one-eared stethoscope of a pattern that his college professor had suggested was good to use on dogs. While the patient was quickly tucking the nether end of his disturbed white waist down over his protuberant abdomen, and endeavoring at the same time to tether his waistcoat and breeches together, so as not to look awry when he passed through the line of waiting frauleins, the doctor rattled on, at a speed our trolleys *once* travelled, that "Chicago" must "Eat no sugar, no starches, use no liquids at meals, have a room on the ground floor, must walk slowly on a level only; and no *coffee*, no ALCOHOL, NO CIGARS. Drink the water I here prescribe. Take two baths likewise. Report in two days. Good-bye."

So soon as the gentleman from the city of large feet caught a good square hold on his breath again, which was just outside the limits of passing the acute he had left, he smote the air in twain several times with ejaculations such as I have occasionally heard in the smoking-room, but never in the parlor. These remarks referred in a definite, specific way to a place opposite the zenith, where thermal springs are indigenous and per-

ennial, and where the odor of sulphur gone wrong is redolent and eternally permeating. He did not like the restrictions. He was sensible enough, however, to give the treatment a fair trial.

#### DURING.

The next morning I accompanied him to the mineral spring where he was to begin the first part of the programme. It was a lovely morning; the band played something or other from Wagner very softly, while the crowds were wandering about sipping their before "frei stück" waters. My friend found that part of his prescription read: "Two hundred grammes Karlsbrunnen, warm, to be sipped slowly while walking leisurely, fifteen minutes to elapse between the first and second glasses." All this before the morning meal. Afterward, while sitting quietly in front of a very simple breakfast, discussing whether the hens of Hesse-Darmstadt understood their business, the patient suddenly, without any apology whatever, left the breakfast-room. Something had moved him. It was the Karlsbrunnen.

Later, I took him to bath-house No. 2, where he bought his bath-tickets, and found that he was No. 184 on the list. With those who had already bathed out of the way, that meant at least an hour's delay. During the interval he read the second part of his prescription: "Bath of eight minutes' duration, in water from spring No. 7, with carbonic acid, at  $32\frac{1}{2}^{\circ}$  Cent. Repeat to-morrow, remaining in the bath nine minutes."

At last his turn came, and he entered his room, and, placing 25 pfennings on his prescription-blank for the attendant, disrobed for the bath. I had then an opportunity of examining him. Percussion showed dulness in the superficial cardiac space, extending a trifle beyond the nipple line, the deep cardiac space being also enlarged. Dulness extended to the right side more than a good finger's breadth. There were no murmurs heard on auscultation; the first sound was fairly good, the aortic and pulmonary second sounds being slightly accentuated. No evidence of fatty degeneration, myocarditis, nor of arteriosclerosis was present. I could not help but feel that the diagnosis of dilatation only told the truth partially, and perhaps the least important part. In my opinion there was a considerable accumulation of fat about the heart and between the fibres,



these accumulations interfering mechanically with the heart's action. With such a degree of enlargement, due to pure dilatation, pulmonary or bronchial and also dropsical symptoms had a just right to appear on the scene. Abdominal plethora was not sufficiently marked for a case of pure dilatation, the liver not being enlarged.

His pulse was weak, and 26 to the quarter when he entered the bath. At the expiration of six minutes the pulse was 86, and much stronger and fuller. When out of the bath, after being dried with hot towels, another examination was made.

The apex beat was not distinctly palpable, because of the thick layer of fat. The nipples were not a reliable guide as to the position of the apex beat, the breasts sagging down too much from adipose weight. Auscultation showed the apex beat to be half under the sixth rib, and immediately beneath the sagged nipple.

The dulness in the superficial cardiac space had receded to just within the nipple line, showing a difference of from  $\frac{1}{4}$  to  $\frac{1}{2}$  inch in the extent of dulness. On the right side there was dulness now only to a finger's breadth. I could detect no changes in the upper (third rib) border of the heart. The pulse was now 90, but of much better quality than before the bath.

(It is not my purpose here to tell the whys and wherefores of this apparent diminution in the size of the heart. I am simply telling a story of things as they seemed to happen. At some future time I shall have more to say concerning the *modus operandi* of the Bad Nauheim treatment.)

He dressed, went to his hotel, disrobed and retired to bed, remained quiet or slept for an hour after the bath.

On seeing the patient next day, at breakfast, he repeated the rapid exit of the day before, and declared he was no better. Pulse, 95; respiration, 22. He had noted, however, that he was passing a much greater quantity of urine than usual.

The bath was repeated, and he declared that he felt tired all over. I had no opportunity to examine him physically before the bath. Afterward his pulse was 90, of fair volume.

He visited his doctor in the afternoon, was declared better, and was ordered the same bath of ten minutes' duration. Next day there was a pause in the bathing. He had nothing to do

but drink his Karlsbrunnen in the morning and take slow walks. In the evening I found him in his room behind a dense cloud of smoke, puffing away like a steam-engine. He looked up, half apologetically, saying: "Couldn't stand it any longer. These are only 5 pfennings a piece. There's not much nicotine in them. *They're not cigars.*" After consulting my nostrils I concluded his diagnosis was correct. Those rank things were not cigars. I presume he resumed his habit on the Koko principle: "Began on a guinea-pig and worked up to a trombone-player." He smoked after that during my observation of him, and his smokers gradually assumed a more civilized odor. The pulse, during his smoking seances, seemed about 95, but weaker than when not indulging.

Following the pause in the bathing, he was ordered a bath with the same ingredients, but with an addition of a litre of mother-lye, to increase the density and mineral qualities of the water. The temperature was also  $\frac{1}{2}^{\circ}$  Cent. lower— $32^{\circ}$ . The duration of the bath was increased to twelve minutes.

At my suggestion a urinary examination was now made and forwarded his physician. A copy of the analysis showed *absence of sugar*, a specific gravity of 10.30, and an enormous quantity of uric acid. This report was simply surprising. The patient himself had noted that, in addition to passing much more water than usual, on standing a little while the urine in the bottom of the retaining vessel showed at times as much as a half-teaspoonful of "red sand." He seemed now in better spirits, walked easier, and showed a tendency to hold himself erect. He could not bear prosperity, however. That very afternoon, while sauntering in the Kur-house park, I found him loaded nearly to the bulk-head with Niersteiner. Like a capital mariner on a twin-screw steamer, his steering-apparatus was all right, but he moved a little heavily in the water. He explained that those — — waiters at the hotel always shoved a bottle of wine at him, and on that particular day the *table d'hote* had been too much for his American stomach, and he had "experimentally" determined to ascertain whether German wine would not sustain him until the evening repast. He declared he had not disobeyed the doctor. "That stuff was not alcohol. The doctor had meant whiskey and brandy, not wine," so he opined. He offended in this particular only twice afterward, to my knowledge.

On one occasion, after he had ascended two flights of stairs to see me about a trip to Johannisberg, I found him much "blown," with a weak pulse of 130, the radial beats being regular as to time, but irregular as to the amount of fullness of the pulse and force of the expansion. In twenty minutes, after resting in recumbency, the pulse-rate had fallen to 100.

After he had taken about seven baths he was put upon the celebrated Schott "resistance exercises," a series of movements also calculated to improve the heart's power when judiciously employed. Movements were now given him half an hour every day.

These were unquestionably of great benefit to him. His heart apparently slightly diminished in size; his pulse increased in volume, although it was not so much diminished in the number of beats as in the baths. He was required to rest half an hour after each seance, although the exercises in no way fatigued him. These resistance exercises were thereafter given daily, even on the days when he had a pause in his bathing.

Subsequent urinary analyses showed a return of a small quantity of sugar, and this for a few days produced a state resembling "the blues," from which, however, he rallied.

At this juncture he was suddenly summoned home by cable-gram. His mother had typhoid fever.

#### AFTER.

The man of gout and dilated heart had had fifteen baths and ten resistance exercises, and these, together with some correction of diet and walking upon the level, brought about these results:

1. A considerable and notable loss of flesh.
2. A clearer head for mental work.
3. A more elastic step and better carriage.
4. An increased quantity of urine, from a quart and a half to two quarts.
5. Almost continuous painless discharge, with each urination, of uric acid crystals.
6. Occasional absence and diminished quantity of sugar in the urine.
7. A diminution in the size of the deep and superficial cardiac spaces of one inch to an inch and a half; heart not yet



normal in size (nor will it be, in my opinion, until he gets rid of more fat).

8. A pulse-rate of 80 to 85, often dropping to normal, and remaining there for hours.

9. A fuller, stronger radial pulse, with fair tension.

10. Scarcely any cyanosis of the lips.

11. Warm hands and feet.

12. Good sleep; good appetite.

13. No dyspnœa, except when putting his heart to a severe test, as walking rapidly up hill or up three flights of stairs.

This, then, is the picture "after" taking the baths and exercises. It must be remembered, however, that the prescribed course had been by no means finished, from five to eight weeks being the usual time given at Bad Nauheim to such a case.

The parting instructions of his physician were to observe the dietary regulations first laid down, and to walk three hours every day; that is, three times a day he was to walk an hour.

For the apparently flippant manner in which I have presented this case the circumstances under which it was written will serve, to the knowing ones at least, as an ample apology. It was written in the smoking-room of the "Friesland," where the Germans were filling the air with the smoke from rank pipes, while the ship seemed to be trying to stand on her head and then see how far she could go over on the side without capsizing, and the children in the steerage were yelling, and a man outside, limply hanging to the rail, was with violent effort trying to bring up his boots and feed them to the fishes. It is the sad remembrance that I was like him a few days ago that makes me now so disposed to write in lighter vein. Besides, too, it has been my wish to convey some idea of the "local" color of a life at Bad Nauheim; in other words, to give some of the lighter details that would not fit becomingly into a more scientific description of Bad Nauheim and its methods.

---

CANTHARIS IN DYSENTERY.—*Burning like fire in the anus*, after the stool; dryness of the lips and thirst during the pain; vesicles and canker in the mouth and throat; collapse, small pulse, coldness of hands and feet.

## SARCOMA OF UTERUS, WITH SERUM TREATMENT.

BY H. R. FARINGER, M.D., NEW YORK.

House Surgeon Metropolitan Hospital, Blackwell's Island, New York.

MARGARET P.; single; aged 64; occupation, none; nativity, U. S. A.

*Family History.*—Father died of heart trouble; mother, cause unknown; grandparents, of phthisis pulmonalis.

*Personal History.*—Began to menstruate at age of 17. Two years prior to this was troubled with sick headache. When the menses did appear they were very irregular and painful. Never gave birth to any children, and had no miscarriages. Menopause came at the age of 44, at which time she was sick a great deal, and had leucorrhœa.

*Present History.*—About one year ago she was taken with flooding, as she called it. The loss of blood was profuse, and accompanied with severe pains in the pelvis; offensive discharge from vagina; continual constipation, with great weakness, and pain down the thighs; loss of appetite and an anæmic appearance; pain more at night, causing loss of sleep. Her greatest complaint now is that she cannot have a bowel movement without great difficulty and pain.

*Circulatory System.*—Weak, regular pulse; slight mitral regurgitation and aortic stenosis.

*Respiratory System.*—Normal.

*Genito-Urinary System.*—January 5, 1898. Pain on urinating.

*Urine.*—Contains large quantities of albumin; no sugar; acid; color, pale; transparent; sp. gr., 10.10. January 30, 1898. Epithelium, bladder and vaginal. Color, light brown and cloudy; sp. gr., 10.18; alkaline slightly; *albumin present*; glucose, negative; urate of soda and triple phosphates present.

*Physical Examination of Vagina and Pelvis.*—Outlet normal; perineum normal, but atrophic; vagina short; cervix enlarged, hard, firm, rough, granular and nodular.

*Uterus Body.*—Immovable, and firmly attached in either right and left lateral region to broad ligaments. The firm

growth has involved the bladder and the rectum. A small piece of the growth was removed from the cervix and subjected to microscopical examination.

*Diagnosis* was made of malignant growth, involving cervix, bladder and rectum, of a sarcomatous variety of tumor composed of round and spindle cells. The growth had so far advanced that all interference in a medical way was out of the question of treatment.

*Treatment.*—As treatment, she received conium, ars. alb., in different sized doses, for several months; vaginal douches of hot water and hydrastine sulph., and mild laxatives to move the bowels. In spite of this treatment the tumor continued to become larger and press on the rectum, so that it was very difficult and painful for her to have a movement of the bowels without excruciating pain, even by very thin stools. Her general condition became gradually worse; emaciation and weakness; pains in the pelvis continued in great severity, and an intolerable itching, as she called it, in the vagina. Morphine was the only thing that gave her ease from the above symptoms, though the after-effects on the bowels was undesirable. The only thing that could be thought of to relieve the bowel obstruction in the rectum was a left inguinal colostomy and the formation of a permanent artificial anus. To this suggestion she readily consented, and the operation was done on the 5th January, 1898, with perfect results. This being a sarcomatous growth, it occurred to me at once that a trial of serum therapy might be beneficial in reducing the size of the tumor, and we resolved to try it. Through the kindness of Dr. Coley I obtained a supply of mixed toxine of streptococcus of erysipelas and bacillus prodigiosus, which was injected into the cervix and surrounding tissues of the tumor.

*January 25, 1898.*—The first injection was made January 25, 1898, at 2 P.M., after the parts were washed and douched thoroughly; also removed another small piece of cervix for examination under the microscope. Upon digital examination, uterus immovable, cervix granular and nodular, bladder and rectum involved, hard and firm. The injection of *one-half* m. immediately into a hard solid mass above the cervix at 2.15 P.M. twenty minutes after she complained of chilliness, which developed into a rigor in about ten minutes. During chill, tem-



perature,  $97.6^{\circ}$ ; pulse, 97; respiration, 29. From this she gradually reacted; pulse and temperature came up, and at 4 P.M. temperature,  $101^{\circ}$ ; pulse, 104; respiration, 24. Fell asleep after 6 P.M., and slept six hours during the night. Received no morphia; felt much refreshed, but no noticeable change in the symptoms; pain and itching.

*January 26, 1898.*—At 11.45 A.M. another injection of serum into the same locality of *one-half* m. 12.05 developed another chill, same as on the previous day. Temperature fell to  $97.6^{\circ}$ ; pulse, 96; respiration, 32, during the chill. Reaction not as profound as on the previous day. Temperature rose to  $102^{\circ}$ ; pulse, 104; respiration, 28; gradually subsided, and by 4 P.M. temperature,  $98^{\circ}$ ; pulse, 84; respiration, 22. Passed a very comfortable night, sleeping nearly eight hours without any narcotics, to which she had previously been addicted. The following morning, at 8.30, temperature,  $98^{\circ}$ ; pulse, 69; respiration, 20. Pains in lower part of pelvis and abdomen not so severe, and had a great deal less itching.

*January 27, 1898.*—Received another injection of serum; quantity, *one* m., at 11.15 A.M. No chill followed this; only a slight rise in temperature. Temperature,  $99.4^{\circ}$ ; pulse, 90; respiration, 24, at 6 P.M. Did not sleep the forepart of the night, but rested well after 12 o'clock. The following morning felt very comfortable. Pain and itching of much less intensity, and felt much better in general. The general appearance much brighter.

*Diet.*—During this time the diet consisted of milk toast, hot milk, eggnog and sarco peptones. Bowels regular and appetite much improved. Later, the diet was increased to medium. Diet composed of soft-boiled eggs, milk, bread and butter, soups, beef meat, rice and fruits.

*January 28, 1898.*—Injection of *ij.* m. at 11.20. Severe chill, followed by sweat and rise in temperature, which was not taken at its height. From this injection she received great ease from pain and itching, which had been more or less constant before; slept well during the night, and woke much refreshed, and was free from pain and itching for long intervals. Complained of pain on urinating, which was due to the sudden relieving of the distended bladder; this disappeared in a few minutes after the act of urinating.

*January 29, 1898.*—Injection of serum, 9.46 A.M., iii. m. No chill followed; only slight temperature; slept well, and profound in character. Upon examination of the involved part, the cervix is softer, and the amount of infiltrated tissue seems less. The cervix and surrounding tissues are less irritable, *i.e.*, bleeding less readily on manipulation; appetite gradually improving.

*January 30, 1898.*—Injection of iv. m. at 10.30 A.M., followed by a vigorous chill, fever and sweat. Temperature rose to 103°; pulse, 130; respiration, 32. Complains of little pain, and slept well during day and night.

*January 31, 1898.*—Injection of v. m. No chill, but slight rise in temperature.

*February 1, 1898.*—Injected vi. m. Considerable slough removed by the douche.

*February 2, 1898.*—No injection given; passed a very comfortable night.

*February 3, 1898.*—Injection of viii. m. at 10 A.M. No chill followed; became restless and thirsty.

*February 4, 1898.*—Injected viii. m. Chill followed; temperature, 101.2°; pulse, 116; respiration, 30; parts much reduced in size and softer.

*February 5, 1898.*—No injection.

*February 6, 1898.*—Injection x. m. No chill; temperature, 99.4°; pulse, 82; respiration, 20.

*February 7, 1898.*—Injection xii. m., followed by chill of one-half hour; temperature, 100°; pulse, 98; respiration, 24; feels very good; only slight shooting pains in bladder region.

*February 8, 1898.*—No injection. Slept nearly all day; upon examination of the parts the growth is much reduced in size; upon palpation the parts posterior to bladder is much softer than on the previous examinations; pains are periodical only when urinating; feels much better in general.

*February 9, 1898.*—Injection of xv. m. at 10 A.M. Several chills followed; temperature rose to 100.4°; pulse, 100; respiration, 24.

*February 10, 1898.*—No injection.

*February 11, 1898.*—Injection of xvi. m. No chills followed; temperature rose to 100°; pulse, 100; respiration, 30.

*February 12, 1898.*—No injection.

*February 13, 1898.*—Injection xvi. m. at 10 A.M. Chills follow; temperature,  $102.6^{\circ}$ ; pulse, 100; respiration, 30; complaints of pain in small of the back; other symptoms no worse than the last time recorded; sleeps greater part of time; appetite good.

*February 14, 1898.*—No injection. Pains in back continue.

*February 15, 1898.*—Injection of xv. m., 10.15 A.M., followed by chill; feels better; temperature,  $100.4^{\circ}$ ; pulse, 98; respiration, 26; pain in back not as severe.

*February 16, 1898.*—No injection.

*February 17, 1898.*—Injection xv. m., 10 A.M. Chill followed. At 12 M. condition about same, with gradual improvement; sleeps well; appetite good; temperature,  $104.2^{\circ}$ ; pulse, 106; respiration, 30.

*February 18, 1898.*—No injection.

*February 19, 1898.*—Injection xii. m., 10.15 A.M. Chill at 12 M.; temperature,  $100.4^{\circ}$ ; pulse, 100; respiration, 30.

*February 20, 1898.*—Pain in back gradually disappearing. No injection.

*February 21, 1898.*—Injection xii. m. at 10.15 A.M. Chill followed; temperature,  $101^{\circ}$ ; pulse, 102; respiration, 26; itching and pain in pelvis and abdomen nearly all disappeared. The only pain that is any way distressing is that accompanying urination.

*February 22, 1898.*—No injection.

*February 23, 1898.*—Injection x. m. Slight chill; temperature,  $99.2^{\circ}$ ; pulse, 94; respiration, 24; feeling very well, but weak; is able to sit up and be out of bed several hours a day.

*February 24, 1898.*—9 A.M. Feels very sick at stomach; vomited bile, and feels bad generally. No injection. Passed a bad night; slight pain in left hypochondriac region.

*February 25, 1898.*—The above symptoms still persisted. R. Ipecac 3x given without any relief.

*February 26, 1898.*—Same.

*February 27, 1898.*—Ars. alb. 3x. During this time her appetite rapidly failed her and she became very weak.

*February 28, 1898.*—Gradually grew worse very rapidly, and went into a typhoid state, semi-comatose.

*March 4, 1898.*—Patient died at 9 A.M. The cause for such a rapid decline in this case after such apparent improvement was unaccounted for until an autopsy was held.



*Autopsy ; General Appearance.*—Rigor mortis present; body emaciated; lungs nearly filled the thoracic cavity.

*Left Lung.*—No adhesion; pleural cavity contains small quantity of fluid; weight 23 ounces; no adhesion between the lobes; lower lobe dark-red and purple color, firm, and does not crepitate on pressure; cuts with a liver-like feel, and exudes a thick fluid on pressure from the air-cells; contains gray nodular areas, size of a pea or larger.

*Diagnosis.*—Pneumonic consolidation of the left lower lobe; sections of the upper lobe float, and of a grayish-red appearance.

*Right Lung.*—Adherent entirely by recent adhesions, and in apex; presents a grayish-red mottled appearance; crepitates throughout; sections exude a frothy fluid, especially in the posterior part.

*Diagnosis.*—Hypostatic congestion; the inferior lobe hypostatic congestion; bronchi normal.

*Heart.*—Normal position; pericardium contains about 5ij of fluid; weight, 12 ounces; the anterior surface has an abnormally large accumulation of fat on its surface, yellowish in appearance, one-quarter of an inch in thickness; the valves, so far as could be seen, showed no cusp deficiency.

*Diagnosis.*—Dilated slightly.

*Liver.*—Adherent to diaphragm; weight, 42 ounces; reddish-brown color; all lobes well defined; sections cut with firm feel.

*Spleen.*—Anæmic.

*Pancreas.*—Anæmic.

*Left Kidney.*—5viii; nodular feel; capsule non-adherent; pelvis dilated, probably due to the pressure of the growth on the ureter, forming an obstruction; cortex gray and atrophied; pyramids are obliterated in places.

*Right Kidney.*—5iiss. Whitish-gray in appearance; capsule adherent in places; two large cavities in pelvis, each the size of a pigeon-egg, caused by ureter obstruction; cortex very thin, one-eighth of an inch, and obliterated in places; pyramids also gone in places; the cavities contained fluid which was relieved when the ureter was cut; ureter also dilated to size of an ordinary lead-pencil.

*Diagnosis.*—Interstitial nephritis, with atrophy. Abdominal

aorta contained calcareous deposits locally between the seventh dorsal and second lumbar.

*Pelvic Contents.*—Uterus tubes and bladder adherent, and tightly bound down in pelvic cavity; large cyst on right side of uterus involving the ovary and tubes; cyst, size of orange, contained a watery fluid; the posterior wall of bladder much thickened; bladder mucous membrane showed chronic inflammation; friable mass of sarcomatous tissue on surface of bladder wall, gray in color and contiguous with the anterior surface of the uterus and cervix; the right lower portion of broad ligament is markedly thickened and infiltrated with the growth, the left side not so much so; uterus cuts with a firm feel, gray internally, and contains an encapsulated mass at the fundus, the mass filling the cul-de-sac and involving the entire right side of uterus; the rectum is also involved, where the cervix comes in contact with the posterior vaginal wall; rectal mucous membrane thickened and granular in appearance; the adjacent lymphatic glands were not involved.

*Microscopical Examination of Autopsy.*—Sections of the lower lobe of lung showed the air-cells to be completely filled with leucocytes and broken-down pus-cells, intermingled with fibrinous deposits; the lung-tissue infiltrated with inflammatory material.

*Kidney.*—Increased interstitial tissue, with obliteration of tubules in large areas.

*Liver.*—Cells undergoing acute cloudy swelling.

*Heart.*—Fatty metamorphosis.

The evidence of the relation of an attack of erysipelas to malignant tumors, especially sarcoma, needs no further mention, as it has been observed, from ancient times to the present day, that an attack of erysipelas caused the disappearance of certain malignant growths.

The exact change that is produced in a tumor by the use of the mixed-toxine of erysipelas is not yet positively known.

Reduction in size of the tumor, not only sarcomatous, but also carcinoma and fibroma, takes place after its use.

The most marked changes in a tumor occur from the use of the toxine directly into the growth, though the use of the toxine is not without constitutional effects, according to size of dose used.

When the serum is introduced into the system at other places than the seat of tumor, the systemic depression follows just the same, but the effect on the tumor is not as marked, *i.e.*, reduction in size and softening, as though it were introduced directly into it—thus leading one to suppose the toxine to have some direct influence on the growth.

Upon microscopical examination of tissue of a tumor before and after the use of the toxine, the cells are found to be less transparent and clear, showing a cloudiness and granulation, after the use of the toxine. At times, following the injection of serum, suppuration and sloughing are caused.

Moullin (in February number of *London Lancet*, vol. i., No. 5) accounts for it by claiming it is a mixed infection, which occurs from the introduction of some pyogenic organisms.

I have found suppuration and sloughing to occur in a man suffering from small round cell sarcoma of jaw and neck.

This case was operated on five times, with recurrence each time; he is now under serum therapy, and shows marked improvement.

Dr. Coley, of the New York Cancer Hospital, has made some valuable and interesting advances in this line of treatment, and classifies the different varieties of sarcoma according to the improvement they have shown:

1. The spindle-shape celled sarcoma showed most improvement and cures.
2. Mixed round cell and spindle shape.
3. Round cell small.
4. Osteo and melanotic sarcoma showed least benefit.

Dr. Coley also has statistics of numbers of cases treated in this way, with the exact result in each. All of his cases were inoperable or recurrent cases of tumor.

This apparently shows the serum treatment deserves consideration in such cases.

---

CAPSICUM IN DYSENTERY.—Thirst after every stool, and shuddering after drinking; stool after drinking; taste like putrid water; tenesmus of the bladder; *drawing pains in the back, which, with the tenesmus, are continued after the stool*, which consists of thin adhesive slime, mixed with black blood, with twisting pains about the navel.



## ASTHMA IN YOUNG CHILDREN.

BY J. E. BELVILLE, A.M., M.D., PHILADELPHIA.

It has fallen to my lot to meet with a considerable number of severe asthmatic attacks occurring in very young children, and owing to the fact that these attacks often simulate more serious affections of the lungs, it would seem advisable to give, as briefly as possible, a short account of their history and clinical course. Two types of the affection are noted by authorities. First, a purely spasmodic type characterized by dry cough, extreme dyspnœa and absence of fever. Cases of this type present no characteristics differentiating them from such seizures in the adult. Second, a catarrhal type. It is to this class of cases I desire to call particular attention. The cases I have met with have occurred in children between the ages of two and one-half and five years. They may occur at any age up to ten years. Attacks occur at any season of the year, but are more frequent during the winter months. At the outset they present the symptoms of an ordinary catarrhal cold. After two or three days the child, if old enough to note its sensations, complains of chilliness. This is quickly followed by a rapid rise in temperature, in some cases as high as  $103\frac{1}{2}^{\circ}$ , and, in one of my cases, reaching  $105^{\circ}$ . Pulse, 120 to 140. Respiration in the cases with high fever, 50 and over. Frequent short, hacking cough. On inspection the accessory muscles of respiration are seen to be actively at work, the soft parts above and below the thorax being drawn in with each inspiration. Auscultation shows the presence of abundant râles, fine and moist.

In a first attack it is almost impossible to make a diagnosis between the disease under consideration and catarrhal pneumonia, the only point of differentiation being the extreme dyspnœa, which is inspiratory rather than expiratory in character (Keating). It is wisest to watch the course of the disease before committing one's self to a positive diagnosis, as the true nature of the affection will usually be evident on the second or third day after the development of the active symptoms, although so

eminent an observer as Trousseau narrates a case in which recovery alone made it possible to arrive at a diagnosis. These patients will have, too, attacks of a lighter form, in which the true asthmatic nature of the seizure will appear. At the end of the second or third day the fever moderates, dyspnœa becomes less marked and the cough becomes looser, the case after that time running along for several days as a catarrhal bronchitis. Attacks of lighter or severer type are frequent, sometimes occurring twice in one month.

The two elements of causation in these attacks are catarrhal bronchitis and enlarged bronchial gland plus excessive irritability of the respiratory centre. In the cases coming under my observation, catarrhal bronchitis has been the most frequent exciting cause. The prognosis is usually favorable. I do not know of a fatal issue in even the severest forms of this affection. As to ultimate freedom from recurrence, Keating says that at puberty there will probably be a cessation in the attacks. From my own experience a much earlier date may be set, a number of cases not showing any return after the sixth year.

The remedies adapted to the treatment of the seizures are aconite, ipecac, nux vomica, kali bichromicum. In the interval cod-liver oil and iodide of arsenic. It has seemed to me that lack of proper ventilation and the practice of using the room in which the children sleep as a living-room, and permitting them to sleep in an atmosphere thus vitiated, has been a factor in increasing the severity and frequency of the attacks. Bronchitis being so prominent an ætiological factor in these cases, careful attention to the clothing of children is of the first importance, avoiding excessive as well as insufficient clothing. In one case I am satisfied that the extreme frequency and severity of the attacks were due to over-dressing and confinement in a close room, the family living in a hotel. Cold sponge-baths, when reaction is readily established, are of marked benefit. Exercise in the open air, and all those adjuncts of treatment so necessary to success, and the importance of which it is so difficult to impress upon parents, must be insisted upon.

---

**NUX VOMICA IN DYSENTERY.**—Stools small, frequent, with violent tenesmus; pressing pains in the loins and upper part of the sacral region, *with sensation as if broken*; the pains and tenesmus cease with the stool.

## TWO PECULIAR CASES OF DIPHTHERIA.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

LAST winter and the preceding fall a diphtheria epidemic visited the little community in which I practiced then, and amongst the cases which came under my care there were two which were quite out of the usual order, namely, one a case of diphtheria in a pregnant woman, who bore a child while the disease was in full force, and the other, one of diphtheria of the navel in a child of a few weeks. Both of these, contrary to my expectations, recovered.

The first was a sturdy and healthy primipara of some twenty years, who, near full term with her first pregnancy, was seized with a severe chill, headache and succeeding fever. I noted nothing beyond these symptoms until the next day; on examining her throat I saw a few small white patches on both tonsils. She had a few wandering and premonitory pains of labor. I gave her *phytol.*  $\zeta$  and *kali permanganate* in solution as a gargle. The fever soon rose to about  $103^{\circ}$ , the pulse remained full, though rapid, her strength failed her, and she took to her bed. I continued the same treatment, with *verat. viride*  $\zeta$  as a fever remedy and *merc. biniodatus*  $3x$  internally. She continued thus for several days, with slight extension of the diphtheritic patches, which were and remained pearly white. I changed the gargle for a swab solution of the same drug, later employing one of carbolic acid and tincture of the muriate of iron in glycerine. After she had been sick for four days, labor came on while the throat disease was present in full strength, and it was very laborious on account of an unyielding cervix. I was finally forced to chloroform her, I being alone and five miles from assistance, at midnight, with a sea of mud between me and another practitioner. I applied the forceps, and only after adding the axis traction attachment was I able to move the child, when it was born easily and quickly. I sewed up quite a tear in the perinæum. With the aid of cloths kept saturated in a solution of the bichloride of mercury,



1 : 100, applied over the perineal wound, I succeeded in keeping the infection from reaching the tear. The patient passed through a tolerable child-bed, and gradually got up again, to become exceedingly fleshy afterwards. But, singular to relate, the diphtheritic patches did not entirely disappear from her throat for *four months* from the date of her falling ill. Her throat never pained her from the beginning to the end of her illness. The baby was not attacked.

At no time was there any enlargement of the submaxillary or adjacent glands of any consequence; the tonsils themselves were not swollen perceptibly.

Trousseau, of Paris (*La Clinique Médicale de l'Hôtel-Dieu*, vol. i.), under diphtheria, mentions some of the cases where the disease has attacked the vulva, vagina and uterus either before or after the throat was involved. Many of these cases ended fatally. I know of a case where, after circumcision in an adult, the diphtheria attacked the wound and meatus.

My second case was that of a little girl of a few weeks, where, in a German family of seven children, a few weeks after delivery of the mother, one of the smaller children was affected with a diphtheritic sore throat. The disease gradually attacked all of the children, yet they all recovered except one, who was affected with a very malignant form of the disease, with great œdema of the cellular tissue of the neck, face and head; the eyes even swelled shut, and the stenosis of the pharynx and larynx was distressing. After the children had recovered, the little baby, whose navel had been dressed by the mother with coarse and dirty cotton, and with no care with regard to its being clean, began to show signs of irritation in the navel, which really had never healed. The surrounding tissues became hard, tense, infiltrated and bluish-red; the navel became covered with a dirty yellowish membrane which could not be detached. The navel, when I saw it, was seemingly about an inch deep, a dirty, yellowish-white cavity, with hard, dirty, bluish-red raised edges. For at least an inch about it the tissues of the abdomen were swollen. The inguinal glands were not much enlarged; no pus could be detected in the cavity. The child had a slight fever, its pulse was rapid, its general condition emaciated and miserable. It had nursed somewhat, the remainder of its food being eked out with milk

drawn through a long-tubed feeding-bottle. I had the wound cleaned three or four times a day with peroxide of hydrogen; then a 1:1000 solution of the bichloride, and dusted in a powder consisting of one part of iodoform to six of boric acid. The child gradually got better, the hole healed up and closed from the bottom upwards, and in two weeks it had healed wholly. It took several weeks for the infant to regain a fair degree of health and nutrition.

I have searched what little literature I have at my disposal, and I have not been able to find any on diphtheria of the newborn in the navel.

It is usually thought that diphtheria is a disease which, without treatment, will surely result fatally. I know of a family of nine children who were all treated by the father alone with turpentine as a local remedy, and all had the disease and recovered. In another family I treated three children out of eight; the others were allowed to run about, and their throats greased, and pepper and salt or salt and vinegar used locally, and these, without treatment, also recovered. One of them that I treated was neglected by the parents, and died asphyxiated the same day that I first saw it. The other children I treated recovered easily, though there was no mistake as to the diagnosis—the pearly whitish-gray membrane, enlargement of the lymph-glands at the angles of the jaw, the stinking breath, the red seam around the edge of the membrane, the occurrence of paralysis after the disease. Curiously enough several of these eight children recovered practically without treatment.

The biniodide of mercury was the chief remedy that I employed. I found it of special value in cases marked by great tonsillar swelling, a dirty yellow membrane that seemed to have sunken into the tonsils, with decided engorgement of the cervical lymph-glands.

I recall another case of a family of three or four children, who went untreated through the whole disease. All the children were quite ill; one had nasal involvement; the membrane spread to the nose, epistaxis supervened, and yet these children all recovered under no treatment beyond grease and salt and pepper locally. Their guardian angels must have watched over them.

Referring to the long duration of the disease, I have noticed in a recent number of a Danish journal another case where the diphtheria actually became chronic, lasting for months. It probably got into the crypts of the tonsils.

In my second case the disease had been present a year or so before in a neighboring house, and the bedding had been stored away after the patients had recovered. . Soon after it had been brought out and aired, the children of this family, a hundred feet away, and next door, who frequented the other house, their grandmother's, fell ill, certainly a fact pointing to the persistency of the virus.

---

#### EYE CONDITIONS DIAGNOSTIC IN GENERAL DISEASES.

BY D. A. MAC LACHLAN, M.D., DETROIT, MICH.

(Read before the American Institute of Homœopathy, Omaha, June 25, 1898.)

THIS is a practical age. The day is past when mere courage, daring or heroism wins battles. Admiral Dewey gloriously demonstrated at Manila that science (brains, practice and precision) is necessary also.

Just so in the battle against disease. The day is past when mere bluff, swagger-belly, sonorous voice and butcher hand made a surgeon, or mere assumed dignity, mystery, fatherliness and a pill-bag made a physician. Science is necessary, and skill also. I think it was Oliver Wendell Holmes who said in effect: "Science is fine furniture for the upper story if there's common sense on the ground-floor; but without common sense in the first story, the more science in the second, the worse for the patient." "Knowledge is power," if well wielded. Medical science we must have, but skill to apply it is the essential to success.

Surgery and therapeutics have been wedded since time immemorial, and "what God has joined together let no man put asunder." There are those to-day who would divorce them, but there is not judge or jury under heaven that can separate them, for they are bound by an indissoluble tie. What is the enduring link that has held and will ever hold them together?



It is the art of diagnosis, for by it only do we know whether surgery or therapeutics is demanded in a given case, or whether, if the physician has charge, the time has come when the surgeon should be called.

The day has passed when the doctor can look wise, say nothing, prescribe on the totality of symptoms, and preside over the feast, or funeral, that results. The handmaids of medicine, hygiene and sanitation, to say nothing of educated public opinion, render it no longer possible to shirk a diagnosis, if that be possible. The patient is not the only one considered; his relatives, his neighbors, and even his fellow-citizens must be protected. Hence, a diagnosis is imperative, and whether or not the surgeon is to be required, and whether or not, in our opinion, ourselves and our patient need it, we may as well prepare to diagnosticate, for "the law allows it and the court awards it."

We shall have need, then, of every means that science or art has placed at our disposal. Even the generally disregarded adjustments and appearances of the eye may be worthy our observation and study for this purpose. We shall find, perhaps, that a look through these "windows of the soul" will reveal the lurking-place of many an interloper and disturber in the temple made for man, the Creator's own image and best handiwork.

It is, therefore, the hope of the writer to direct your thought and attention to this unique and indispensable organ as a means of deciphering the signs of destruction and disorder in the complex structures of gray matter and white matter, of neuroglia, cells, fibres and axis-cylinders that go to make up that mysterious and wonderful mechanism called the nervous system. Inasmuch as this latter controls and regulates, excites and inhibits every organ and tissue, every thought and action of the human being, we are likely by its manifestations to learn the cause, character and location of many of the injuries and diseases that humanity is heir to. Of necessity I must be brief, and therefore can only refer to a few of the general diseases to which the eyes may furnish a clue even if they do not tell us all we seek to know concerning the whereabouts and evil designs of these lurking foes of human kind.

Beginning with the external portions of the eye, a good many

suggestions and signs of general disease may be noted. Inability to close the lower eyelid denotes paralysis of the orbicularis due to lesion of the facial nerve, such as tumor, otitis, specific disease, injury (parotid), etc. Ptosis, or drooping of the upper lid alone, indicates a cortical nervous lesion located just in front of the anterior central convolution, or, hysteria. Bluish circles occur from menstruation, injuries of the eyes, etc., and pigmentation of the lids denotes hepatic or uterine disorder. Brown patches on the lids point to Addison's disease. Edema of the lids points to heart or kidney disease, drug poisoning (arsenic), and trichinosis, in which it is not only an important but often the first objective symptom. Congestion or inflammation of the lids denotes eye-strain usually, but gastric, uterine and ovarian disease also.

Yellow conjunctiva tells even a layman of liver derangement, as extreme pallor does of anæmia or cachexia. Conjunctival extravasations of blood in old persons denote atheromatous degeneration, and often precede apoplexy; in the young they occur in whooping-cough, after epileptic paroxysms, etc. Phlyctenular ulcers of the conjunctiva or cornea point to some dyscrasia or low vitality, due to struma and infectious or septic diseases, tuberculosis, and eczema (especially nasal), delayed menstruation, etc.

The cornea presents several diagnostic appearances. The arcus senilis, the gray line about the edge of the cornea in older people, may be a sign of fatty degeneration of other tissues, and is associated with fatty heart. Neuro-paralytic ulcer of the cornea denotes a lesion of the trigeminus from disease of the nerve itself, syphilitic deposits, or fracture of the skull. Xerosis or dryness of the cornea and conjunctiva is also sometimes due to affections of the trigeminus, but is more often seen in children with severe diseases, such as scarlatina, measles, typhus and cholera infantum, and in adults with jaundice. It usually denotes impending death, and its disappearance marks improvement. Interstitial inflammation or infiltration of the cornea is the chief diagnostic sign of the cornea; it indicates inherited syphilis in about 70 per cent. of all cases. It occurs between the ages of six and twenty years, is always chronic, and generally accompanied by other familiar signs of congenital syphilis, viz., peculiar formation of the face and skull, Hutchinson's

teeth, deafness, enlarged glands, swellings of the periosteum, etc. Occasionally it is observed in acquired syphilis, and more rarely still in scrofula.

The iris affords a vast number of indications of general diseases, particularly in the domain of the nervous system. Ordinarily irides are alike in color and brilliant in lustre. A dull, sluggish iris is an early sign of inflammation which is usually a manifestation of congenital syphilis in children, as iritis is a disease of adults. In the latter it is indicative of rheumatic, scrofulous or tubercular diathesis, or of specific disease, a very large per cent. of all cases being due to acquired syphilis. It should not be forgotten, however, that traumatism, infection and extension from other parts account for many cases, and that an irregular appearance of the iris is often due to previous inflammation, with adhesions (anterior or posterior synechiæ), or to congenital defects, such as coloboma, persistent pupillary membrane, etc. A tubercle or papilla in the iris is almost always a syphilitic gumma.

It is in its movements, however, that the iris does us the greatest service in diagnosis. Normally the pupils are equal in size, and inequality is always pathological. They contract equally when light enters both eyes or only one eye (consensual reaction), and a failure to do so indicates blindness; it is therefore a very valuable diagnostic sign in many conditions.

The pupils contract from the following: Stimulation of the optic or motor oculi nerves, or of their centres; paralysis of the sympathetic nerve; accommodation and convergence; fulness of the iritic vessels, and effects of certain drugs (miotics). And dilate from: Paralysis of the optic or motor oculi nerves and injury or destruction of their centres; stimulation of the sympathetic; sensory or emotional stimuli; anæmia of the iritic vessels, and effects of drugs (mydriatics).

Of pupillary signs in diseases of the nervous system, it may be stated that they are present only when the lesion is above the junction of the sympathetic with the spinal cord. It may be said also, in a general way, that dilatation of the pupils indicates pressure on the brain, contraction indicating irritation; dilatation occurs more often in brain disease, contraction being the rule in spinal lesions. Spinal disorders, with dilatation, point to simple irritation (stimulation of sympathetic); spinal



symptoms, with contraction, point to a destructive lesion (paralysis of the sympathetic).

The state of the pupil often furnishes us with the first clue to brain or spinal diseases; and as cure so frequently depends upon treatment being begun early, the importance of the knowledge of pupillary indications may be appreciated.

Dilatation is caused by hæmorrhage, abscess, tumors and injuries of the brain, meningitis (late stage), hysteria and epilepsy (late stage), melancholia, anæmia, trigeminal disease, eclampsia (uræmia), diphtheria, whooping-cough (marks the change from catarrhal to convulsive stage), diffuse encephalitis, trichinosis, exophthalmic goitre, and by the following poisons: Aconite, amyl nitrite, atropine, belladonna, bromide of potash, cocaine, carbonic acid, cyanide of potash, duboisine, daturine, ergot, ether, ethyl nitrite, gelsemium, glonoin, hyoscine, hyoscyamine, oxalic acid, stramonium and various ptomaines.

Contraction of the pupils is caused by insanity, parietic dementia, epilepsy or hysteria (early stage), locomotor ataxia, multiple neuritis, sleep, dyspnœa, sclerosis, and by the following drugs: Eserine, curare, chloral, chloroform (dilatation denotes impending asphyxia), iodoform, muscarine, pilocarpine, physostigmine, opium, tobacco, etc.

Myosis and inequality of the pupils is characteristic of tabes, hysteria, neurasthenia, etc.

Reflex rigidity of the pupil is diagnostic of bulbar paralysis, sclerosis and parietic dementia. A paradoxical reaction of the pupil, dilatation in the light and contraction in the dark, is recorded from poisoning by coal-gas and illuminating-gas. Hippus, or rapidly alternating contraction and dilatation of the pupil, is a symptom peculiar to hysteria and a few irritative brain disorders.

Contraction is the rule in the early or irritative stage of inflammatory affections of the brain and its membranes, as well as of cerebral tumors, hysteria, epilepsy and similar conditions.

Laminated cataract is a sign of rickets.

Affections of the voluntary ocular muscles often assist greatly in locating brain lesions; they consist of either spasms or paralysis. Mere irritation of the visual centres causes spasm, while destruction of the same part causes paralysis. Many times spasm is only the first stage of paralysis, and one is

usually as important as the other in locating the disease. In apoplexy the head and eyes are both turned toward the side of the lesion (conjugate deviation), and relaxation from this position, especially if the head and eyes can be turned to the opposite side, denote recovery. Conjugate deviation is common in cerebral abscess also; and in the course of either apoplexy or abscess, if fresh irritative brain symptoms (spasms and paralyzes of various sorts) supervene, it denotes rupture of blood or pus, respectively, into the ventricles.

Irritative symptoms (spasms, twitching, nystagmus, miosis, conjugate deviation, etc.) first, and later, paralysis, mark the gradual growth of cerebral tumor. The same may be said of basilar meningitis before and after exudation has taken place, and of cerebral hæmorrhage and other cerebral conditions that are progressing during minutes, hours or days, symptoms at first irritative becoming paralytic as the growth or extent of the lesion increases. Nystagmus, a rather rare symptom in brain disease ordinarily, is so common in multiple sclerosis as to be diagnostic. The nystagmus is due to interruption of conduction between the oculomotor cortex and the nuclei of the ocular muscles, and hence locates the lesion. The parts of brain involved are: Cortex (centres of highest rank), nuclei (centres of lowest rank), the nerve-trunks (basal), or the bands of fibres connecting nuclei with nerve-trunks.

The following table may assist in diagnosing the site of lesions, while other associated symptoms may explain their character:

MUSCLES OR NERVES PARALYZED.	SITE OF LESION.
One muscle only (of oculomotor).	Below the nuclei. (Except ptosis, which may be cortical.)
Conjugate paralysis, or deviation (lesions of associated centres).	Crura cerebelli, pons, corp. quad. and great ganglia of brain (op. thal., etc.).
Ext. ocular muscles alone (accom. and convg. retained).	Nuclei (floor of 4th vent.). (Excludes basilar lesion.)
Abducens and facial together.	Probably nuclear.
Oculomotor of one eye, with opposite extremities.	Pedunculus cerebri.
Abducens and facial, with extremities.	Posterior part of pons.
Whole series of cranial nerves.	Base of brain.
	<div style="display: flex; align-items: center;"> <div style="margin-right: 10px;"> <div style="display: flex; align-items: center;"> <div style="font-size: 2em; margin-right: 5px;">{</div> <div> 3d, 5th, 7th, Optic, Olfactory. </div> </div> </div> </div>

MUSCLES OR NERVES PARALYZED.		SITE OF LESION.
Beginning as neuralgia of 5th.		Base of brain.
One optic nerve (unilateral blindness).		“ “ “ (below chiasm).
Ophthalmoplegia with	Orbital pain or tenderness.	
	Deep-seated tumor.	
	Protrusion of globe.	Within orbit (extra cranial).
	Optic neuritis, one side.	
	History of trauma.	

Hemianopsia, or loss of one-half of the visual field without the ophthalmoscope showing any changes in the fundus, enables us to locate a lesion of the optic tract. If the defect is *for one eye only*, the *lesion* must be in the optic nerve itself, *in front of the chiasm*. In *temporal hemiopia* (loss of both outer fields of vision) the *lesion* is *in the chiasm itself*, the discussing fibres being destroyed. In *homonymous hemiopia* the defect is symmetrical, *e.g.*, loss of outer half of one eye and inner half of other; the *lesion* must be *above the chiasm*. If, in addition, the *pupil doesn't react* when light is thrown upon the blind portion, the *lesion* is in the *optic tract*, *below* where the fibres are given off to *oculomotor nucleus*; but if the *pupil does react*, the *lesion* must be *above* this point, in the *thalamus*, etc., or even in the *cortex*.

Optic neuritis, or inflammation of the optic nerve, is rarely a local disease, and therefore its diagnosis is of the highest importance to both the oculist and the general practitioner, as it is an index to so many general diseases. The field for diagnosis of all the conditions previously mentioned is as open to the physician as to the oculist; but in this skill and experience in the use of the ophthalmoscope is required, and the specialist will usually need to be consulted. Neuritis should always be suspected in the course of nervous affections if the pupil is dilated and vision disturbed, while otherwise the eye seems normal externally.

In the course of brain diseases optic neuritis is brought about by *pressure on the nerve* within the cranial cavity, producing simple engorgement of the papilla (choked disk); or, *by direct transmission* of the inflammation from the brain along the nerve and its sheaths (neuritis descendens). Cerebral tumors and hydrocephalus cause the former by gradually arrogating to themselves space in the cranial cavity, while the latter is usually due to meningitis. Other causal diseases are: cerebral



hæmorrhage, embolism, thrombosis, abscess and injuries; parietic dementia and multiple sclerosis; syphilis, Bright's disease, diabetes; acute infectious diseases, such as typhus, scarlatina, measles, small-pox and diphtheria, scrofula, disorders of menstruation and pregnancy, acute anæmia, lead and other drug poisoning, and taking cold.

In the form of choked disk it is almost pathognomonic of cerebral tumors, being present in about 90 per cent. of all cases. An examination of the fundus even in the early stage of tumor will frequently enable a diagnosis to be made. The inflammation may appear early or late, but, if late, it indicates that the growth is increasing, and the prognosis is bad accordingly. Choked disk is generally bilateral, but one eye is often affected first. It develops quickly, as a rule, and after weeks or months is followed by atrophy of the nerve and more or less permanent blindness.

Simple atrophy is frequently an early symptom of locomotor ataxia, and, along with the Argyle-Robertson pupil (no light reaction and miosis) and absence of the patellar reflex, makes an early diagnosis of tabes possible. It occurs also in other affections of the cord and brain, and is almost always bilateral, but may not begin in both eyes at the same time.

Impaired vision and inflammation of the retina are sometimes the first signs discovered of kidney lesions. Sudden loss of sight, with retained pupillary reactions, in adults, and during pregnancy, should lead to an examination of the fundus and of the urine at once. Retinitis, with the characteristic yellowish-white patches about the fovea centralis, would diagnose Bright's disease. Retinal hæmorrhages, too, are significant, as they so often precede apoplexy, especially in aged persons.

Disseminated choroiditis, with cloudy vitreous, is diagnostic of syphilis. Sudden blindness occurring in one eye, with a cherry-red spot at the fovea centralis, means embolism in the central artery of the retina and permanent blindness, and usually points to heart disease. Pulsation of the retinal arteries, synchronous with the radial pulse, and alternating with the retinal veins, is a sign of aortic insufficiency, and rarely also of mitral disease.

Protrusion of the eye-ball forward is a well-known sign of

Graves's disease; also of aneurism of the internal carotid (pulsating exophthalmos) and of paralysis of the recti muscles.

The eye furnishes some diagnostic signs even in the dead. Opacity and insensibility of the cornea, absence of the pupillary reaction to light, the so-called sclerotic patch, a desiccated spot to the outer or inner side, or below the cornea, and xerosis of the conjunctiva and cornea, develop very soon after death, and denote almost unmistakably that life is extinct.

---

THE DIAGNOSIS OF BARLOW'S OR MOELLER'S DISEASE.—Dr. C. Baron, of Dresden, from study of the literature and observation of a number of cases of scurvy in children, or the so-called Moeller's or Barlow's disease, has found at the beginning, (1) *risés of temperature to be the rule*; (2) *an anamic appearance*; (3) *a slightly rhachitic tendency*; and (4) *an enlargement of the spleen* was observed. (5) *The gums were more or less inflamed*. In most of the children there was a sort of (6) *false paralysis from subperiosteal effusions of blood, chiefly of the lower extremities*, though these are not exclusively affected, for the upper have been noticed to be involved. The duration of the disease ranges between six and eight weeks and exhibits no typical course.—*Muenchener Medicinische Wochenschrift*, No. 18, 1898.

This disease, which was first described by Moeller, of Koenigsberg, Prussia, as an acute rhachitis, and later by the London physician, Barlow, rightly as an infantile scorbutus or scurvy, is characterized by the *rapid course, the painfulness of the bones, especially of the epiphyses, and accompanying fever. The gums are spongy and possibly bleeding*. Children raised on the bottle are generally affected, and during the first 4–18 months. At first sight such child appears to be affected with *acute inflammatory articular rheumatism!* On account of the painful limb it lies wholly motionless, and on the slightest movement or touch it groans, and scarcely therefore sleeps at all. It seems well-nourished, but pale and with moderate rhachitis. The pain and swelling are *not* in the joint, but at the noticeably thickened epiphysis. The gums usually are not always swollen, but bluish-red, and easily bleeding around the incisors already broken through. No petechiæ of the skin, though the eyelids may be oedematous and suffused with blood. The child, especially its head, sweats easily and profusely. The parents will usually say that the child had been raised on cow's milk or preserved milk, and had been well and hearty until recently, but during the past few weeks it had become very restless, sweat a great deal, and acted as if it had pains in its legs. The disease runs an acute course, and with proper treatment terminates, in two or three weeks, in recovery. If unrecognized it may drag on for months, and by exhaustion and accidental complications end in death. As to treatment, give fresh and *unsterilized* or unboiled milk and beef-juice, and, as medicine, two to three teaspoonfuls of orange- or lemon-juice.—From Nil Filatoff: *Kurzes Lehrbuch der Kinderkrankheiten*, p. 154. Vienna, 1897.

## EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

## THERE IS BALM IN GILEAD.

SINCE our last writing the Board of Medical Examiners, whose session was then imminent, has gotten in its work, and, according to all accounts, the casualties resulting from their activity exceed, proportionately, those attending the patriotic efforts of our soldiers at Santiago. The latest reports from the medical department of the army are very encouraging, showing that, by the use of antiseptics, wounds are made to heal very kindly, and that the formation of pus is almost unknown. We will hope that the wounds inflicted by the Medical Examiners may take the same benign course, and soon be healed without lasting "mortification." To contribute to this end we would wish to apply some antiseptic treatment, trusting that it may not be too late to cause them to heal "by first intention."

It is peculiarly unfortunate that the rejection of an unusually large number of candidates for license should follow so closely upon the discussion of the "general utility business" of the Board, in which several of its members took so earnest and public a part. It has very naturally, though perhaps unjustifiably, given rise to a wide-spread impression that the answers of the applicants were subjected to an unusually severe criticism in order to demonstrate the necessity for a revision of the work of the colleges by a Board of Examiners. Without acknowledging that we share this impression, we cannot but think that it is a natural one when it is considered that among the number of those temporarily placed *hors de combat* by the long-range fire of the Board there were several who had always stood well up in their classes at college, and whose application as students would have reasonably precluded the idea of the possibility of a "flunk" at the hands of a discriminating Board.

But let us apply our antiseptic treatment in the shape of an attempt to answer the question: "In how far can the result of



examinations before a Board of Examiners, as at present constituted, be considered conclusive as to the fitness of a candidate to begin the practice of medicine?"

Let us in the first place look at the two parties concerned, the Examiners and those to be examined. As to the Examiners, we all know that, however fortunate we have been in the personnel of our Board, it has not been by reason of any universally acknowledged pre-eminence in their profession that its members have obtained their appointments. We speak without fear or favor, but with the greatest good-will. While they are all, so far as we know, honorable men, successful practitioners, and prominent in their several localities, none of these qualities would have been sufficiently pronounced to have forced recognition had not other influences been equally potent.

They are physicians of large and long experience, and would naturally in their selection of questions and in their judgment of the answers be influenced by their own personal views based upon this. In the more practical branches this "personal equation" can hardly fail in many cases to work disastrously for the one who has graduated under teachers with different views and different experiences. In other subjects, the liability to be at variance with the teachings of the teachers is equally great, if not greater, in consequence of the various ways of looking at a subject, and the varied degrees of importance attached to individual facts by different minds. What a teacher, in his systematic effort to lay a certain foundation for future work on the part of his student, may have passed over with but slight reference, may have struck the Examiner, in his desultory reading, as of the utmost importance, ignorance of which would condemn the student to a poor mark.

We have seen questions requiring categorical answers upon subjects still in dispute; questions also upon theories not yet generally accepted, and therefore not legitimate subjects of teaching, and surely not of such an examination. We have seen questions evidently prompted by some lately-acquired personal experience, and not likely, therefore, to have been the subject of any emphatic teaching in a college course. In short, we have seen questions based upon antiquated and obsolete views, as well as questions culled from the latest ephemeral

journalistic science, while of course a great many have been fair, legitimate, practical questions. Of these latter, however, there have been many to which more than one correct answer could have been given—correct according to the standpoint of the questioner.

Examining thus the Examiners, we find nothing in their position, nothing in their personal experience, to render their decision as to the qualifications of a candidate conclusive, while we do find many circumstances which could be supposed to bias such decision.

Turning now to those to be examined. They have passed through a course of study which has surely made great demands upon their mental energy. They have just emerged from a fortnight of examinations of the most varied and trying kind. They are now compelled to refresh their memories and to “cram” as much as possible in studies which have been laid aside for two years, and to submit to another trial, and that in writing, the outcome of which is legally to confirm or nullify the hard work of four years. Let us all acknowledge how rapidly those facts of which we have not been called upon to make use during the later years of our practice fade from our memories. Let him who does not practice surgery, or obstetrics, or gynecology, ask himself how much of what he once knew is still within his conscious reach. Let him who is not accustomed to express his thoughts in writing endeavor to put down on paper a few of the answers required. Let these tests be made by each one with as vivid a realization as possible that the result is to decide his future, and then let him answer the question whether the result obtained could be regarded as conclusive proof of his fitness or unfitness to begin the practice of medicine.

We must take things as they are, and not expect impossibilities. The students have had the various subjects in the curriculum presented to them by different teachers, and they have unconsciously stored away what knowledge they have obtained under certain, for them, well-defined rubrics, and an attempt to reach it, and make it available, by any other route than that by which it has been acquired, is apt to prove futile. When, therefore, they find among the questions in Hygiene one which

by no possibility can be made to belong there, they may not be able to answer it; whereas, if it had been presented to them under Practice, where it belongs, they would find no difficulty. The flexibility of mind, and the grasp of actual knowledge, which come only with long training of the mind, is naturally wanting in most of the young graduates, and their inability to answer certain questions is no proof that they do not possess the knowledge which would enable them to do so under other circumstances.

Anyone acquainted with the laws of association by which the workings of the human mind are governed, and anyone accustomed to teaching, recognizes the truth that even a well-known fact may elude the grasp if the wrong train of ideas be set in motion.

But it may be objected that this very inability to find and to make use of knowledge possessed, argues against the fitness to practice medicine. To this we can only oppose an *argumentum ad hominem*. How many of the members of the various boards, how many members of the profession at large, did not possess this inability at the time of their graduation? Has it not been the work of years, and is it not even yet our greatest task, so to connect our isolated bits of knowledge as to have them always at hand, or within our reach? Much as we have a right to expect from the present graduate, can we in justice demand of him all that which we recognize in ourselves as the result of experience and mature study?

Finally, by the answers to ten questions in the various branches the amount of knowledge of those subjects, and the consequent fitness to begin the practice of medicine, is to be judged. Of the character of some of the questions we have spoken, and could say much more, but the absurdity of the above proposition in itself is sufficiently evident without appealing to this. We could get around the absurdity by appealing to the principle that the greater includes the less, if—but there's the rub—we were sure which was the greater and which the less, or if all, teachers and examiners, were agreed upon that point. As it is, however, we often find, according to our notions, "mint, anise and cummin" tithed, and the "weightier matters of the law" neglected.



We sum up, therefore, our antiseptic treatment of the wounds of the rejected candidates in the assertion that the results of the examinations before the State Board of Medical Examiners cannot be justly regarded as conclusive as to the amount of knowledge possessed, nor as to the fitness to begin the practice of medicine.

As a further permanent antiseptic dressing, we say that these examinations, here and elsewhere, as at present conducted, are serio-comic tragedies. They are at once too easy and too difficult. Too easy, if it is really desired to discover the amount of knowledge possessed, and made too difficult by the circumstances attending them, if it is only to be decided whether the men are fitted to begin the practice of medicine.

That the present system is bound to be modified we feel sure, and that we may not seem content with bare fault-finding, we suggest for consideration the following, as partial improvements of the method:

I. The selection for Examiners of those only who, by their writings and public work, have become recognized authorities on the subjects of examination, each such authority to examine in his specialty individually.

II. Oral examinations to take the place of the present written ones, or at least largely to supplement them.

III. The privilege to be accorded to intending graduates to come up for examination in the several branches at the close of their college course on those subjects.

These regulations would obviate what seems to us, under the present system, to be every year a more imperative necessity, viz., the co-operation of the teaching bodies in the selection of questions, if justice is to be done to the candidates.

They would further allow of much more thorough and rigid examinations, without increasing the burden of the student. The extra work thrown upon the Examiners would only be in the line of their duty, and of the carrying out of the ostensible purpose of their appointment.

Finally, the results of such examinations could be regarded as conclusive, and a license to practice, based upon them, would *then* have more than an arbitrary legal value.

## THE OMAHA MEETING.

THE 1898 Institute meeting was characterized by smallness of attendance, intense heat, poor hotel accommodations, splendidly-adapted place for meetings, unusual interest in sectional work, election free from any unpleasantness, continuous good-fellowship, and unremitting attention of the local physicians.

The great interest and large attendance of the one thousand homœopathic physicians in the vicinity of Omaha did not materialize, as promised. Fifty or more men from surrounding towns appeared the morning of the election, and disappeared as silently as Longfellow's Arabs, after the contest was over. The smallness of numbers was due, in our opinion, to the remoteness of the place of meeting from the geographical centre of Institute membership, to the financial state of the country, and to the recent unwarrantable attack upon members who have been constant, in season and out of season, in the service of the Institute. At Atlantic City, neither old age and service nor youth and enthusiasm will be considered a crime. The same was true at Omaha, but it was not so understood by many.

Climatic conditions are uncontrollable, and the torrid temperature of the first two days on the banks of the Missouri was Omaha's misfortune, and not her fault. The only thing comparable to the heat was the warmth of welcome extended by the local committee. The receptions were all appreciated, especially the one given by Dr. Wm. H. Hanchett. The members present soon gathered on his spacious lawns, and thoroughly enjoyed the cool breezes.

The meetings were held in the new building of the Creighton Medical College, which seemed to have been built especially for this convention, so admirably was it adapted for the purposes of the members present. If four hundred instead of two hundred members had been on hand its capacity would have been overtaxed, and failure would have been the result. The local committee, however, sized the attendance to a nicety, and now wear with becoming modesty the laurels of success. The Old School people very kindly rented their building to the local physicians for the use of the Institute.

The business transacted was put through with a thorough-

ness and dispatch that reflected great credit on Dr. Wright's administration and added much to the comfort of the members present, and the scientific work claimed an earnest attention that has seldom if ever been equaled. One section had an attendance of nearly everyone present at the Institute, and continued in session for three hours with the temperature of the room ranging distressingly near the 100° mark. This same active, earnest interest pervaded all the sectional work, and promises well for the future.

Dr. Bailey, of Lincoln, Nebraska, after an aggressive canvass, conducted in a manner above criticism, won the presidency. The rule of electing a man president who has only attended five meetings of the Institute is a dangerous one. Still every rule has its exception, as the meeting of '99 will prove. Fortunately in Dr. Bailey the Institute has a man with good initiative and ready adaptability, which, taken with his character, intelligence and attainments, fit him for the peculiar responsibilities of the high office he has been elected to fill.

The unanimous selection of Atlantic City as the place for the 1899 meeting was a good one. It means the largest meeting in the history of the Institute.

One hundred new members were added.

Once again it was painfully evident that the meetings are too long-drawn-out. The vast majority of members do not care to devote ten days to two weeks to the Institute. The sessions should be concluded in four or four and a half days. This can be done by allowing two sections to report at the same time, being careful to arrange the sections so that direct interests will not conflict. For instance, surgery and clinical medicine, or obstetrics and neurology, or gynecology and materia medica, or pædology and ophthalmology can hold sessions side by side at the same time and have no clash of interests, each section having a whole day to report, and yet get through in four or four and a half days.

---

CITRATE OF SILVER (ITROL) FOR GONORRHOEA.—(Werler.) Itrol possesses an intensely destructive effect on gonococci without injuring the urethral mucous membrane or increasing the inflammatory symptoms. He begins injections as early as possible to destroy the gonococci, and uses a solution (0.025 : 100.0), four injections a day, gradually increasing to a strength of 0.05 : 200.0.—*Centralblatt für Gynäkologie*, No. 9, 1898.



## GLEANINGS.

---

THE DIAGNOSIS AND PROGNOSIS OF CEREBRAL HÆMORRHAGE AND APOPLECTIC STATES.—Prof. Gilles de la Tourette, of Paris, states the necessary increase of cerebral arterial pressure for the rupture of an artery is very great—from the normal, 8-12 mms. of mercury to 150-200 mms.—though this is easier with a degenerated artery. Old age, gout, alcohol, and poisoning by various substances force its development.

Contracture setting in suddenly after the stroke, with rigidity of the limbs and convulsive succussions of the affected side, with a tendency to extend to the other side of the body, offer a very serious prognosis: inundation of the ventricles or a large extent of cortex. The age of the patient is of importance, though young persons may from syphilis be stricken with apoplexy. *The temperature* is of the greatest importance diagnostically and prognostically. At first it falls, possibly to 36° or 35°; but in a few (three or four) hours it rises to 38-39°. *Note this!* If it remain below 39° you may expect a survival of the patient. However, if it continue to rise to 40°, or even 41°, 42°, 43.2°, you may predict a rapidly fatal result. Rarely, it may range about 38°-39°, and death follow after several days. *Great contraction of the pupils is another ominous sign.*

If conjugate deviation of the eyes and head are present, then, even if the temperature be but little elevated, *one should hesitate as to a favorable prognosis.*

The comparatively rapid appearance of acute decubitus is ominous, *i. e.*, of a bullous eruption on the thighs, to be followed by an ecchymosis, for then death is liable to follow in two to three days. A bulbous eruption on the paralyzed member, though less unfavorable, is of serious prognostic import, as well as the inflammation or ulceration of a part subjected to only slight pressure; the toe, for example. In aged or weakened persons where, though the temperature be but little elevated, the apoplexy drags along with a comatose or semi-comatose state, the outlook is gloomy. In four to six days the temperature should be normal.

Will paralysis follow? If there be conjugate deviation of the head or eyes it certainly will follow, and be situated on the side toward which the head looks. "*Le sujet regarde sa lesion.*" If facial paralysis complicate, an affirmative answer may be given. "*Le malade fume la pipe.*" In twenty-four to forty-eight hours the muscular tonicity reappears, and the extent of the paralysis will then be manifest. Besides cerebral hæmorrhage and embolism, which two present the same clinical picture, the coma may be due to:

1. *An intra-cranial neoplasm.*—Here a one-sided headache, which was limited to a single point, with (a) *gradual appearance of the coma*, the patient being stupid, somnolent *for days before*; (b) he had complained of *lack of power in one side of the body*, and a weakness of vision; (c) *optic neuritis*,

which is detectible ophthalmoscopically ; (d) The coma is of longer duration than in hæmorrhage ; (e) convulsive seizures in an arm or a leg, with a local paralysis, all aid in its diagnosis. The temperature *may* be elevated.

2. If traumatism be suspected, look for a hæmatoma, a fracture with depression or overriding of fragments, bleeding from the ear, or the presence of brain-substance from these apertures. The thermometric rules applicable in cerebral hæmorrhage also apply here.

3. If the individual be comatose, with bloody foam on his lips, his tongue bitten, he is probably epileptic. Wait a while and he may recover consciousness. Even here the temperature may be elevated. If it reach 40° and convulsions, tonic or clonic, set in, he may succumb to his disease, status epilepticus.

4. Numerous poisonings with various drugs are associated with comatose states, as that from alcohol, aconite, digitalis, stramonium, opium, hyoseyamus and belladonna.

*Here a fall of temperature aggravates the outlook.*

(a) After a massive dose of alcohol a stupid state supervenes—"dead-drunk." Here the temperature falls, and continues to fall if death is to follow.

(b) Opium has absolute coma, with a scarcely perceptible pulse, the pupils contracted, no stertor (?), the extremities cold, and death occurs from heart-failure. Vomiting is rarely absent. Look for brownish stains on the lips, clothing, etc. Tincture of opium presents a similar picture.

(c) Belladonna dilates the pupil. Observe it !

5. Uræmic and diabetic coma are relatively frequent. In uræmic coma gastro-intestinal disturbances, dyspnœa and convulsive seizures may precede. Examine the urine, to eliminate doubt, not only for albumin and sugar, but also for casts. If the temperature be abnormally low, look out for trouble ahead ! It may rise and still the coma remain ; *an apoplectic seizure complicates*. The coma of uræmia, and especially of diabetes, is graver prognostically than that of cerebral hæmorrhage.

6. Hysteria may be complicated with apoplectiform or comatose attacks. Here the antecedent history is of value. But the temperature is absolutely *normal*. The eyelids vibrate successively in a fine tremor which is never noticed in other comas. A hysterogenic zone may be detected which on pressure will bring about awakening or a convulsive attack. In all cases, take the temperature immediately. Do not forget that hysterics may have an apoplectic seizure during a hysteric attack ; a vaso-motor diathesis may develop in hysteria which leads to trophic troubles and, possibly, to a genuine apoplectic seizure.—*La Semaine Médicale*, No. 32, 1898. (Poisoning by carbolic acid may also produce a comatose state similar to that of opium. Whitish stains on the lips, mouth and fauces, and the odor of the drug, as well as the dark-greenish urine—carboluria—will diagnose it.

THE TONSILS AS GATES OF ENTRANCE FOR SEVERE GENERAL INFECTIONS. —Dr. F. Jessen, of Hamburg, calls attention to the importance that the tonsils, "the physiological wounds" of Gerhardt, present as points of entrance for serious infection of the general organism.

Diphtheria, with its classical faucial membrane, and the succeeding infection of the organism and its consequences, is a well-known picture.

(Trousseau described a rheumatic tonsillitis long before the present writers called our attention to it.—*Trans.*)

Buss asserts that 70 to 80 per cent. of the cases of acute art. rheumatism begin with a tonsillitis. (?) I have observed two such. See HAHNEMANNIAN MONTHLY, 1894.

Richardière, Hanot, etc., have reported cases of descending lymphangitis, pleuritis, sepsis and death following a non-phlegmonous tonsillitis, due to streptococci and staphylococci.

Cryptogenic sepsis is in many cases preceded by a tonsillitis. (Dennig.)

Scarlatina is thought to be due to a mixed infection through the tonsils by many writers.

Tuberculosis of the cervical lymphatic glands has been found to be dependent on passage of the bacilli through the tonsils (Schlenker). The writer reports a number of cases illustrating his views. A man of 30 years fell ill with grave general symptoms, pains in the joints, confusion of mind, and tonsillitis. On one tonsil there was a dirty greenish, on the other a yellowish, membrane; temperature 39°; painful enlargement of the cervical lymphatics. On the third day there was noted on the forearms, legs and face, as well as back, an eruption of small papules; at the same time very severe articular pains. In eight days disappearance of the erythema and pains in the joints. Internal organs remained unaffected. Bacteriological examination of the tonsillar exudate revealed the *staphylococcus* and the *streptococcus*, in pure culture. This case is of interest as it presented a perfect picture of gangrenous diphtheria, with which, bacteriologically, it had nothing in common.

A second interesting case was that of a woman of 28 years, who was brought to the hospital with a diagnosis of typhoid fever. Widal's reaction negative. Epithelium of tongue desquamated decidedly. Great cyanosis; skin of extremities petechial; no roseola. Spleen palpable; lungs unaffected; heart not dilated; sounds distinct. Temperature 40.8° Albuminuria and casts in urine (epithelial). Twitchings in the left arm. Death in twelve hours, with out any change. Diagnosis: sepsis and uræmia. The necropsy revealed inspissated pus in both tonsils, though the surface was smooth and apparently normal. The kidneys were large and filled with numerous disseminated small abscesses.

He also records the case of a 17-year-old chlorotic girl who died in twelve days after an attack of tonsillitis with a migrating pneumonia, to which succeeded pericarditis, pleuritis and renal irritation.

Another interesting case is where a woman of 24, who, after a tonsillitis, had a double pneumonia, then a pericarditis, and finally sepsis. Many cases of scrofulosis he has cured in a short time by removing a pharyngeal tonsil.—*Muenchener Medicinische Wochenschrift*, No. 23, 1898. I have seen two cases of articular rheumatism which began with a tonsillitis—one was of a suppurative variety.

A POINT IN THE TREATMENT OF SCARLATINOUS NEPHRITIS.—Dr. Max Hurwitz in a case of this disease where, with decided œdema of the lower extremities, penis and scrotum, and quite an amount of ascites, all treatment had failed to bring about an improvement: purgatives, diuretics, warm baths with hot packs and sweating. Recalling the assertions of old Romberg and Heim that the best diuretic was venæsection, a teacupful of blood was drawn from the patient's (a boy of 7 years) arm. The result was magical. Already the next day the œdema disappeared, and under different treatment the case recovered entirely.—*Deutsche Medicinische Wochenschrift*, No. 23, 1898.



**MYIASIS OF THE NOSE AND EARS.**—Dr. Antonio Nores, of Buenos Ayres, S. A., in his inaugural dissertation has collected forty-three cases of myiasis—five of the ear and thirty-eight of the nostrils. The larvæ were of different species. He recommends the bichloride in the treatment. A decoction of the albahaca (sweet basil) is used in the Argentine Republic to dislodge the maggots. He has found it of no service.—*Anales del Círculo Médico Argentino*, No. 4, 1898.—I have observed a case of myiasis of the ear. An old and discharging otorrhœa attracted a fly which laid two eggs that hatched out. A weak solution of carbolic acid, syringed in, immediately brought them out. They had given the patient a great deal of distress. "I felt as if I had a saw mill in my ears." The maggots were active as seen with the ear speculum. I failed to grasp them with the ear-forceps.

**A CASE OF FATAL POISONING WITH KEROSENE.**—Dr. A. McDougal reports the case of a little girl of 14 months who died in an hour and fifty minutes after having drank a little over an ounce of coal-oil. Soon after drinking it she became unconscious and had four attacks of spasms of a few minutes' duration. After the convulsions there were rigidity of the extremities, rolling up of the eyes and cyanosis. No vomiting while an attempt to wash out the stomach failed. She soon collapsed, the respiration became slow (10), deep and sighing. The pulse was good, not very rapid; no cyanosis while the conjunctival reflex was present. Heart paralysis set in with death. On opening the body the lungs were found congested, œdematous, and smelling of coal-oil. The trachea normal. The œsophagus was slightly hyperæmic. The stomach contained quite a quantity of dark mucus, with drops of the oil; the contents had a strong odor of coal-oil. The mucous membrane was pale. The upper part of the intestines also was filled with a semi-fluid mass, smelling of the oil.—*Norsk Magazin for Lægevidenskaben*, No. 5, 1898.—I once was called to a boy of 4 years who had swallowed an ounce or so of a mixture of coal-oil and goose-grease. He had no bad effects from it. Prof. Axel Johannessen has reported a fatal case of poisoning by coal-oil in this same journal, 1896, p. 565.

**APPENDICITIS IN YOUNG CHILDREN.**—Dr. S. Monrad has done us a service in directing our attention to the peculiarities of this affection in young children, in an excellent dissertation presented to the Medical Faculty of Copenhagen. Etiologically it generally is due to a catarrh extending from the intestines into the appendix. He doubts the possibility of the uric acid diathesis bringing about a localization of infection here.

He admits the possibility of absorption of pus, yet thinks it must necessarily be sterile (which is a question). In small children generally, diffuse peritonitis is very frequent, adhesions do not form as readily as in older children and in adults, and when formed they break easily, thus scattering the pus on to the peritonæum. Such patients should be examined with the greatest care, and never under an anæsthetic, as with the absence of the patient's controlling expressions of pain and the resistibility of the muscles one may do irrevocable damage by bursting the tender adhesions. Two of his cases illustrate this. One should never examine under an anæsthetic without being prepared to operate at once, if pus be diagnosed. The prognosis in children under 6 is enormous: 80 per cent. against 20–30 per cent. in children after this age.

The difficulty of immobilizing the intestines in small children renders early operation the more imperative. Wherever operative measures are necessary it will be indicated during the first twenty-four hours, or possibly earlier, to prevent the appearance of diffuse peritonitis. From an allopathic standpoint, where opium does not act promptly on the local and general symptoms an operation will be called for, as the effusion will grow so rapidly and especially in the streptococcic invasions, that there is no time for the formation of adhesions. Many cases will be saved when we do not wait several days for opium to act. Operation should be limited to a simple incision, as any unnecessary manipulations or extirpation of the appendix may rupture the tender adhesions and spread the virulent pus over the peritonæum. It is doubtful whether his advice not to drain after extirpation of the appendix is good counsel.—*S. Monrad Kliniske Studier Appendicitis hos Børn*. Kjøbenhavn, 1898, 192 pp. Dissertation.

SCARLET FEVER WITHOUT A RISE OF TEMPERATURE.—Dr. Renon, of Paris, reported to the Société Médicale des Hôpitaux of that city the case of a child affected with tonsillitis without fever, where a scarlatinous eruption followed with a temperature of 37.4° and a pulse of 90. The eruption was typical, and a complete desquamation succeeded, during which the axillary temperature did not rise above 37.4°. The eruption seemed typical. No medicines had been given, nor was there any albuminuria. In similar cases the pulse has been noted to be at 110 to 120. Dr. Rendu recalled a case in the midst of an epidemic where there was a scarlatinous eruption without fever, and another of scarlatinous tonsillitis without eruption or fever.—*La France Médicale*, No. 14, 1898.

Prof. N. Filatow—*Diagnostik und Semiotik der Kinderkrankheiten*, 1892, p. 414—mentions these forms as anomalous scarlatina. The apyretic variety has been observed, but scarlatina without tonsillitis is *very rare*. A scarlet fever without exanthem is also distinguished—scarlatina sine exanthemate. Scarlatina without tonsillitis is one of the greatest rarities, and is only distinguishable where another patient is in the house, or where the source of infection is known. This form must be differentiated from rubeola scarlatinosa, sudamina rubra, eruptions from inunction of vaseline, oils, grease of various kinds, as well as that of various drugs, as belladonna, quinine, salicylate of soda, chloral, antipyrin, opium, iodide of potash, etc., the prodromal eruption of a pneumonia or the small-pox.

FRANK H. PRITCHARD, M.D.

GNORRHŒAL RHEUMATISM.—In the reports of the Metropolitan Hospital B. I., New York, service of Bukk G. Carleton, M.D., Dr. J. L. Peek says: Since the introduction of the Esmark bandage, by Dr. Carlton, in the treatment of gonorrhœal rheumatism, the results have been brilliant. The bandage is applied as follows: If the rheumatism is in the knee the bandage is applied beginning at the ankle and encircling the leg to the lower border of the knee; beginning above the knee, another bandage is applied enclosing the thigh. The bandage is wound sufficiently tight to obstruct circulation and left on from fifteen minutes to one hour, according to the tolerance of the patient. The bandage acts by destruction of the gonococci, due to their deprivation of oxygen. A cure is effected in from one to six applications.—*N. Y. Medical Times*, June.

W. D. CARTER, M.D.

A SUGGESTION TO BE USED IN ABDOMINAL INCISION.—In performing laparotomy Scherck (St. Louis) has noticed that, after the abdominal incision has been made, it frequently occurs that from the frequent introduction and manipulation of the fingers through the abdominal incision the peritonæum becomes separated, to a greater or less extent, from the muscular tissue. Appreciating the fact that several complications can arise from this condition of affairs, Scherck suggests the introduction of a stout ligature through the centre on either side of the incision, about half an inch from the margin of the wound, this ligature being tied snugly, and a loop of from four to six inches allowed to remain beyond the first knot. We accomplish by this procedure two results: Firstly, we prevent the separation of the peritonæum from the tissues overlying; and secondly, we have two retractors which take up no room and cause less traumatism than the ordinary metal retractors. When the operation is completed the ligatures are cut and removed, and the wound brought together according to the method adopted by the surgeon.—*International Journal of Surgery*.

FRACTURE OF ELBOW-JOINT; TREATMENT.—The fragments can in no way be so firmly and exactly replaced and held in position as by forcibly flexing the forearm on the arm. The final results, in thirty cases treated by putting the forearm in acute flexion, by careful measurement and comparison with the results obtained by the older methods of treatment, show that the former gives a greater average degree of motion. After the forearm has been placed in position, it is held by a strip of adhesive plaster carried around the wrist and about the upper arm as high as possible. The weight of the hand may be supported by a narrow sling around the wrist and over the neck, but a full arm-sling is not necessary. Probably early motion increases the amount of deposit and the density of the bands of adhesions, so that the rest of the joint for from four to six weeks is to be recommended.—*Journal of Medical Sciences*.

H. L. NORTHROP, M.D.

CIRCUMCISION OR DILATATION?—Many parents will not consent to circumcision. Here dilatation is a safe and acceptable alternative. In the interest of the child, the foreskin is a needed and proper covering to protect, and at the same time keep sensitive, the glans penis. The claim that circumcision renders the male less liable to specific contagion in his excursions into the by-ways of life is unworthy of serious consideration. It is hardly within the province of the surgeon to operate in order to render his patients immune in the field of libertinism.—Still further, gonorrhœa, and syphilis, even, are not infrequently met with in the circumcised. On the whole, I prefer dilatation unless in very exceptional cases, where for special reasons circumcision may be preferable.—Benjamin Edson, M.D., in *July Medical World*.

WHITLOW.—The *Hahnemannian Advocate* for June has as its leading article a paper reproduced *in extenso* from the *Monthly Homœopathic Review*. The author is John M'Lachlan, M.D., B.Sc., Edin.; F.R.C.S., Eng. An extensive drug symptomatology is given. Speaking of the surgical treatment he says: "Are we never to use the knife in whitlow? I would not go so far as to affirm that it should *never* be used, though I have not used it for years, and if I had to use it I would look on the case as a failure, not of homœopathy, but of my powers to apply it properly." It is well to know



the homœopathic remedy in these cases and a good plan to administer it in conjunction with our surgical treatment, but the man who does not early incise in paronychia periosteï or true bone felon, and thus permits the death of the bone, or who does not give free exit to the pus of an ordinary runaround and thus permits an extension up the tendon sheaths is on a criminal equality with the man who advises a poultice for these conditions.

**CIRCUMCISION OF GIRLS.**—Without presuming to pose as their Moses, I do feel an irresistible impulse to cry out against the shameful neglect of the clitoris and its hood, because of the vast amount of sickness and suffering which could be saved the gentler sex if this important subject received proper attention and appréciation at the hands of the medical profession. . . . Indeed, if one were to choose the most important spot in point of influence over the entire system, it would have to be the clitoris and its hood. The state of sexuality dominates the bodily vigor, but the condition of the sexual organs, as a whole, bears no more important relation to the general health of the body than does the condition of the clitoris and its hood to the health and tonicity of the sexual system itself. By all means, then, let the girls have as fair a start in life as the boys. And while we are striving to check the tendencies to sensuality in the male sex, let us not forget the importance of the same valuable office for the female sex. . . . Sensuality is sufficiently pitiable and mischievous when boys are neglected, but the neglect of the girls is still deeper and more disastrous, if possible, in its consequences. It is much easier to prevent than to cure. So let both sexes have a fair start in life, and and be entirely freed from the sexual self-consciousness which inevitably comes from impinged terminal nerve-fibres about the clitoris and its hood, as well as at the glans penis and its foreskin.—Dr. E. H. Pratt, in *Journal of Official Surgery*, March, 1898.

F. WALTER BRIERLY, M.D.

**THE USE OF FORCEPS, ESPECIALLY IN NARROW PELVES.**—(Toth.) After a careful review of the subject he summarizes as follows :

1. The high-forceps operation is not so dangerous either for the mother or the child as has been considered; on the contrary, it is undeniably a safer method of interference for both than version, especially when the version is from the head to the breech.

2. In all cases where, in a high position of the head, labor must be terminated in the interests of the mother, and in cases in which version is contra-indicated, an attempt should be made to deliver with high forceps rather than perforate a living child.

3. In all cases of contracted pelves of the first, or even of the second degree, where the contraction is at the brim, we prefer high forceps to prophylactic version, especially if labor cannot be terminated by natural efforts. This would particularly apply to labors in which there is a relative disproportion on account of excessive development of the child.

4. In case of failure of the high-forceps operation further delay is not allowable, but perforation should be performed at once. Under favorable circumstances symphyseotomy may be considered, but podalic version is contra-indicated.

5. Tarnier's instruments are preferred for the high application of forceps.

—*Archiv. für Gynäkologie*, Part I., page 109.

# PACKING OF THE PUERPERAL UTERUS AFTER INTRAUTERINE OPERATIONS.

—Hahn recommends irrigation of the emptied uterus with a one per cent. solution of lyssol, and packing it with aseptic strips of gauze dipped in a one per cent. solution of lyssol, after the introduction of the whole hand or the fingers in the puerperal uterus for the removal of an adherent placenta, or after curetting for abortion. The tampon remains as a rule forty-eight hours, but in putrid abortion should be removed in twenty-four hours. He uses ergot almost always before the introduction of the tampon. More or less blood and serum always remain within the uterine cavity, and usually becomes the source of septic infection. The purpose of the ergot is to contract the uterus and compress the tampon, which provides perfect drainage of the fluids squeezed out of the uterus. The gauze is comparatively dry when removed, and he has never seen retained fluid in the uterine cavity flow out on removing the gauze. —*Centralblatt für Gynäkologie*, No. 15, 1898.

THE EFFECT OF DIABETES MELLITUS ON THE FEMALE SEXUAL ORGANS AND THEIR FUNCTIONS.—(Gräfe.) He attaches special emphasis to the frequent occurrence of pruritis vulvæ with diabetes. He recommends for local treatment of pruritis washing the genitals with a mild soap, and then disinfection with a weak solution of permanganate of potassium. The patient also can have a weak solution of cocaine if the use of the permanganate is not sufficient to relieve the itching. Sore spots are touched with a 10 per cent. solution of nitrate of silver. Pregnancy has most serious consequences for a diabetic woman, and should not be allowed to occur. A woman with sugar in the urine should never marry.—*Ibid.* GEORGE R. SOUTHWICK, M.D.

STERILITY.—Dr. W. Gill Wylie, of New York, in speaking of sterility caused by antelexion of the uterus, says that the trouble is not caused by the antelexion, but by the endometritis which always accompanies it. The antelexion of the uterus in young girls is due to the fact that the brain is allowed to develop at the expense of the pelvic organs. The undeveloped uterus is an easy prey to any catarrhal disease which attacks it. The uterus which is always flexed in early life remains so; and the real cause of the whole trouble—the flexion, the dysmenorrhœa, and, later, the sterility—is imperfect development. He treats his cases in the following manner: The os internum is dilated, the uterus curetted, and a hard-rubber drainage-tube one and one-half to two inches long is inserted. An Albert Smith retroversion pessary is then introduced into the vagina, to hold the cervix back in the cul-de-sac. Thus any contraction of the uterus will force the tube in and prevent it being expelled from the uterus.

The patient is kept in bed for a week. The tube is then removed and the patient allowed to go about the room, and at the end of another week allowed to go home. If the dysmenorrhœa returns after one or two painless periods the treatment may be repeated, and in rare cases he has employed it a third time, inserting a smaller tube, and leaving it in the uterus one or two months. The patient must be cautioned to take an occasional douche, and to refrain from sexual intercourse and bicycle and horseback-riding while wearing the tube.

He cautions against the use of a straight dilation for divulsing the uterus, for it will be checked at the internal os if there be any flexion, and will go right through the uterus if sufficient force be employed.—*The Am. Gyn. and Obst. Journal*, June. W. D. CARTER, M.D.

PARENCHYMATOUS KERATITIS A SEQUEL OF INFLUENZA.—The case, that of a young man of eighteen years of age, commenced seven days after recovery from the exciting disease. With the exception of a slight amount of bronchial catarrh, the patient's general health when first seen seemed perfect. There was no trace of syphilis or other dyscrasia. There were all the symptoms of acute interstitial keratitis.

All the layers of the cornea were infiltrated, this being more pronounced in the centre of the membrane. The treatment instituted was: Rest in darkness, atropia, hot compresses, with pilocarpine twice a week.

In a week's time vessels commenced to penetrate the corneal tissue from above, and improvement became manifest. At the end of six weeks' time recovery was absolute and complete, vision having risen to seven-sixths. The most striking facts concerning the case were that both eyes were attacked with the same intensity, and the brief duration of the disease.—Lensberg Hilbert, *La Clinique, Ophthalmologique*.

THE PHYSIOLOGICAL AND THE PATHOLOGICAL PUPIL.—(a) That there is no standard of size for the pupil in health, but inequality of the pupils is always pathological.

(b) That contraction of the pupil in health should take place upon the application of light stimuli or convergence of the eyes, but not necessarily upon accommodation.

(c) That dilatation of the pupils in health should take place when causes producing contraction are removed or upon irritation of the sympathetic system.

(d) That miosis and mydriasis in disease may be due to irritation or paralysis, and that the use of eserine or atropine will determine this point.

(e) That the pupil is a valuable guide in the administration of chloroform.—Dr. Frank C. Todd, *Annals of Ophthalm.*

HYSTERICAL APHONIA.—Two distinct types of the affection are recognized—one in which the aphonia accompanies hysteria, with other pronounced symptoms, and the other variety in which the aphonia appears suddenly, with or without an exciting cause.

The treatment which accomplishes good results usually owes its success to the influence of suggestion, though faradism, applied both externally and internally, is very serviceable. The Oliver method consists in pinching the posterior part of the arytenoid cartilages between the thumb and index finger (thus producing an approximation of the vocal cords), and at the same time vigorously shaking the larynx and calling upon the patient to make an effort to phonate, assuring him positively of his ability to talk.—Sanger Brown, *Am. Med. Surg. Bulletin*, vol. xii., No. 4.

CHRONIC LARYNGITIS, CAUSES AND RESULTS.—The author says that, in his opinion, the ordinary text-book causes for chronic laryngitis, viz., phthisis, tuberculosis, tobacco and alcohol, have little to do with its causation. On the contrary, the condition of the upper air-passages, the nose, the nasopharynx and pharynx, have all to do with it. He cites a number of cases to show that relief may be had by curing the lesions in these localities. The writer also shows that graver difficulties arise out of the chronic laryngitis, which itself dates back to these earlier lesions, and supports his position by quoting excellent authorities, such as Rault, Sajous and Mackenzie.—John F. Woodward, *Gailard's Medical Journal*.

WM. SPENCER, M. D.



## MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND  
THERAPEUTICS.

THE THERAPEUTIC USES OF SOLANUM CAROLINENSE.—Milwain, of Jackson, Tenn., has for three years been interested in *solanum carolinense*, and has endeavored to give it as thorough a test as possible. He concludes that in small doses it has no therapeutic value whatever (in acute cases), but its curative properties are beautifully shown in large doses, *i. e.*, one-half to one drachm. He has found that, given in these quantities three times a day, it will produce occipital headache, vertigo, diarrhœa, and a relaxation of the system generally. These symptoms were taken from persons who suffered from epilepsy, and who were taking the remedy as a preventive, although at the time free from seizures.

The writer has apparently used it in convulsive seizures of all kinds, no matter of what nature, and claims that he cannot recall one in which it was not of benefit. It is, he thinks, absolutely specific in the spasms of children; and, finally, a tampon saturated with the oil of *solanum carolinense*, and firmly applied against the cervix, will produce painless dilatation as nothing else will.—*American Medical Monthly*, June, 1898.

THE TREATMENT OF PSEUDO HAY FEVER.—Under the above designation Townsend, of New York, describes a disease closely resembling the true hay fever, but differing from it in its sudden onset, the relief between paroxysms, and the absence of periodical recurrence during the summer months. He has no routine treatment to suggest, but declares that each case must be analyzed, and the cause or causes found, if possible, and removed. If a growth or any source of irritation exists in the nose, it may call for operation. If the pelvic organs are diseased, appropriate treatment is required. The organs of digestion and elimination must be interrogated, and, if not doing their work well, given the assistance needed. Mental worry or overwork may indicate the need of rest or change of surroundings.

Remedies aid much in effecting a cure, and the writer depends more than formerly on symptomatic indications. Arsenicum iod., euphrasia, sanguinaria, ignatia, strychnine and gelsemium are beneficial in many cases. Cold baths in the morning, and friction with a coarse towel or brush, are valuable adjuvants to treatment. Attention to diet and daily routine, with assurance of ultimate cure, is of much assistance. Tonics may be called for if the nutrition is faulty. Local treatment is necessary in most cases, and is advisable in all, if only to obtain the mental effect on the patient.—*Hom. Eye, Ear and Throat Journal*, May, 1898.

ERGOT IN ABORTION.—Dr. Dyce Brown, of London, quotes at length from an article of Dr. Lombe Atthill, of Dublin, ex-Master of the Rotunda Hospital, who in the *British Medical Journal* (March 6, 1897), states his experience of the value of giving ergot for some weeks before labor to women who were liable to post-partum hæmorrhage, instead of waiting to give it at the time of labor. Incidentally he recalls his experience in cases of threatened abortion, and states that he always administers ergot to women threatened with abortion. In some it produces no effect whatever, in a few it induces uterine action and the expulsion of the ovum; in the majority the threatening symptoms disappear, and pregnancy proceeds normally. He is satisfied that if the ovum is not blighted ergot acts as a uterine tonic, and renders the organ in many cases fitted to undergo the further changes which take place in it during utero-gestation; but if the ovum is detached and blighted, then it becomes, as it were, a foreign body, and ergot is likely to stimulate the uterus and to expel its contents.

Dr. Brown remarks that here we have an important fact stated by a well-known authority from his own observation—that in a majority of cases of threatened abortion treated with ergot, the threatening symptoms subside and the case goes on to term; and that where the ovum is expelled, it is because it is already so far detached as to be practically a foreign body, and beyond the reparative powers of the system. These conditions are so similar to the well-known effects of the drug when administered in full doses that Dr. Brown is justified in accusing the author of attempting, by means of his references to its tonic action on the uterus, to throw dust in the eyes of his readers. His knowledge of the law of similars has made it possible for Dr. Brown, for years past, to take advantage of an action of ergot upon which his old-school confrère has apparently stumbled by chance.—*Monthly Homœopathic Review*, June 1, 1898.

LACHESIS IN CLIMACTERIC NEURASTHENIA.—In connection with a case of neurasthenia at the menopause, Halbert states that lachesis in its proving has a poisonous action simulating the venom of the viper; as a clinical remedy its symptoms are those of the adynamic forms of disease; pathologically it develops asthenic inflammations, malignant degenerations, and a general tissue-depreciation which is slow in development and still slower in the tendency to recovery. Primarily we observe its action upon the pneumogastric, and, secondarily, in the blood-inoculation which permits fibrin decomposition. Through the pneumogastric it permits a loss of vasomotor inhibition, and hence the undue afflux of blood at different centres. Thus we see the heart-depression, and the gastric and alimentary functional crises, and the uterine disorders, particularly at the time of the menopause. As it shuts off the vagus inhibition, it permits successive dilatation of the vaso-dilators, until by exhaustion they cannot act in consonance with the vaso-constrictors. Then occur the pronounced changes in the active functions like menstruation.

Physiologically, the "change of life" simulates the vital depression observed in the proving of lachesis. The nervous energy necessary for regular menstruation naturally becomes exhausted as a woman approaches the middle of her life; the cerebro-spinal system loses its elasticity, and pneumogastric inhibition is weakened. It is then that we notice the peculiar nervous phenomena which are incident to the time of life when all the energies are waning, and

the system is trying to adjust itself to a new order of existence. Therefore, lachesis, with its similar symptoms, is often indicated at the climacteric.—*The Clinique*, June 15, 1898.

**COCCULUS IN VERTIGO.**—Halbert, of Chicago, in the course of a clinical lecture, refers to the fact that vertigo may be either objective or subjective. There is, from some cause, a disturbance in the visual appreciation of external objects or a mental lack of comprehension of what the eye sees. In such instances we may really term it objective perversion, because the particular object is not comprehended by a proper focus or else it is not understood in its natural condition. In other words, all comprehension is apparently normal except with reference to that particular object or that particular relation or distance.

There is, however, another form of vertigo in which the fault is due to systemic disturbance within the patient. For some reason there is a vertigo under all conditions and relative to all objects. In other words, the fault is with the patient entirely, who feels himself moving, falling or swimming, as it may be. This is purely subjective, and generally it is associated with nausea or disturbances of the stomach, together with a sick headache. It is this class of cases which should call our attention to cocculus. We find its principal action is upon the solar plexus, hence the symptoms characterized by the loss of appetite, aversion to food, nausea in the morning, nausea with salivation, sick headache, and all the peculiar gastric disturbances, with the sensation of something abnormal in the stomach.

A case is reported which affords evidence of the value of cocculus in subjective vertigo when the irritation begins in the region of the solar plexus and gradually develops into the neurasthenic type with the occipital headache and lumbo-sacral irritation.—*The Clinique*, June 15, 1892.

**THE MEDICINAL TREATMENT OF MENINGITIS.**—Bailey, of Lincoln, Nebraska, reviewing the subject of meningitis, discusses the medical treatment. Avoid bromides in material doses as you value hope. Adhere strictly to the indicated remedy, except in case of convulsions, when the careful use of chloroform will probably give the best results. In the writer's experience the indications are usually covered by one of the following remedies: apis, arsenicum, belladonna, bryonia, rhus, ferrum phos., phosphorus, calcarea phos. or carb., sulphur, zinc, baccillinum, iodoform.

Iodoform is a comparatively new remedy in meningitis, and the writer considers that, although it was first introduced as a remedy for tubercular meningitis, it is likely to prove as serviceable in one form as another. Martel (*Revue Internationale*) reported seven cases cured. He used an ointment composed of iodoform, three ounces, in vaseline, two ounces; and having shaved the head, one-half drachm of the ointment was rubbed into the scalp twice each day. Miner, of New York (*North American Journal of Homœopathy*, February, 1896), reported three cases cured with iodoform used at first internally in the 6x and 2x, but in the third case cured by the iodoform ointment after having been given up to die by eleven physicians. In the *Hahnemannian* (December, 1897) Martin, of Pittsburg, reports two cases of probable tubercular meningitis cured with iodoform 2x. The trituration in all these cases was given in water. This remedy in the opinion of many is



strictly homœopathic, and, though we must admit its first use by the so-called regular school, it was a step in the dark which they have yet recognized as in accordance with the law of similia.—*The Medical Counselor*, June, 1898.

F. MORTIMER LAWRENCE, M.D.

**IODIUM IN PNEUMONIA.**—Dr. Laird recommends iodine in the mother tincture, in the second and third stages of pneumonia. He administers a few drops in half a glass of water, a teaspoonful being given every hour.—*Journal Belge d'Homœopathie*, No. 2, vol. 5.

**MEZEREUM IN SORE THROAT.**—In the *Leipziger Populære Zeitschrift fuer Homœopathie*, Nos. 9 and 10, 1898, an anonymous correspondent recommends mezereum in a variety of sore throat in those who have had syphilis, or have been treated with mercurials. It is characterized by a sensation of burning in the fauces, pharynx and œsophagus, which often increases to a feeling as if one had swallowed pepper or peppermint oil. Sensation of a plug in the throat when not swallowing; worse on breathing fresh air. The voice, otherwise strong enough, fails on attempting to read aloud. The secretion of mucus is not decreased.

**A FEW REMEDIES FOR NEURASTHENIA.**—At a recent sitting of the Société Française d'Homœopathie, Dr. Tessier recommended aur. fol. in the associated cerebral depression and anacardium in neurasthenia following mental work, while phosphoric acid he would reserve for that after venereal excesses. Dr. Marc Jousset, in the treatment of a neurasthenic, had found nux mosch. 6x, coce. 6x, ferr. 12x, and carb. veg., of service. He has cured a case of agoraphobia with arn. ix trit. once a day, for a long time. Dr. Parenteau has had the greatest success with ignat. amara ambra grisea, aurum, arg. nitr. zinc., con. mac. and canth. Dr. Léon Simon, when the disease is the result of brain overwork, has succeeded with carb. acid. and hell. niger; when it succeeds abuse of the sexual organs, he has noticed the best results with selenium. He also points out the efficacy of acon., chin., sulph., colch., natr. carb., nux mosch. and anacardium.—*Journal Belge d'Homœopathie*, vol. v., No. 2.

**CINA IN ENURESIS NOCTURNA.**—Dr. H. Goullon, of Weimar, Germany, thinks cina 2x a very reliable and, in fact, about the only remedy worthy of trial in wetting the bed in children.—*Leipziger Populære Zeitschrift fuer Homœopathie*, Nos. 11 and 12, 1898.

**NITRIC ACID IN RENAL LITHIASIS AND CHRONIC INTERSTITIAL NEPHRITIS.**—Dr. Mossa, of Stuttgart, cites three interesting cases reported by Dr. Kidd:

1. Lady B., aged 78, suffered for five months from gravel. Very difficult and painful urination; urine pale and very acid, with a notable quantity of uric acid gravel, whose passage gave rise to a very painful and frequent strangury. He prescribed ten gtts. of acid. nitric. dilut., in half a glass of water, four times a day. Amelioration soon followed and persisted. The urine took on a dark color in twenty-four hours, and threw down a copious precipitate of the urate of ammopia. Finally the uric acid disappeared, and the dark, turbid and thick urine was passed without pain, to the surprise of the patient.

2. A boy of four years had suffered for a year from irritation of the bladder and incontinence of urine, caused by uric acid gravel in the urine. Acid.

nitric. dil., four drops in a glass of water, four times a day. The incontinence of urine disappeared, according as the nitric acid caused a displacement of uric acid formation. A slight recurrence after a year yielded in eight days to the acid. "The effect of nitric acid was prompt and very marked where the alkalies had failed."

3. A boy, aged three, who had suffered for several months from strangury and dysuria, was placed under treatment, in a miserable condition. His urine was pale, scanty, very acid, containing an abundant sediment of uric acid crystals; his appetite was poor, his tongue covered with a pasty and whitish coat. He had taken alkalies in various forms, and the mineral waters of Ems, Vichy and Carlsbad, which had ruined his appetite without ameliorating his bladder. Dilute nitric acid, three drops in a half-glass of water, three times a day, half an hour before meals. His appetite soon improved, he picked up, and after taking the remedy for eight days the urine became dark, the crystals of uric acid vanished and a cure followed.

4. A man who had for a long time a granular degeneration of the kidneys and chronic gout presented great painfulness of the feet, with œdema. He passed an abundance of pale urine of a sp. gr. of 1010, which contained a moderate quantity of albumin. Microscopically, there were numerous crystals of uric acid and granular casts. The disease had lasted for three or four years. Nitric acid, dil., seven or eight drops in a glass of water, three or four times a day. The result was striking. The gouty attacks became less frequent, the urine darker and its sp. gr. heavier. All the uræmic signs disappeared, together with the œdema. His health remained quite tolerable for several years, though the state of his kidneys would ultimately render his disease fatal.—*Revue Homœopathique Française*, No. 1, tom. ix.

SENECIO GRACILIS IN DISEASES OF WOMEN.—Dr. Frederick Kopp states that senecio gracilis has the power of rendering the periods early, late, or even of suppressing them. It is consequently of service in the amenorrhœa of young girls, with dropsy. In dysmenorrhœa from anæmia it has a good reputation. It is employed especially in strumous cases, where the pain is worse at night. It is also used in other forms, whether the menses be abundant or scanty, provided that there be disturbances of urination. In retarded menstruation it acts rapidly and efficaciously, rivalling some of our best uterine remedies, as puls., caulo., calc. carb., erigeron can., and sepia. It is used where the menses are too early and abundant, to be given during the periods. It is frequently indicated in irregular menstruation, whether it be too early or late. When the flow has stopped from a cold, senecio will often cause it to reappear. Very frequently, in young girls, a leucorrhœa will replace the flow at the same time that they suffer from urinary complications. This complex yields rapidly to senecio gracilis. It is also a grand remedy in scrofulous young girls. If dropsy be present, it is the more indicated. It is sometimes useful in disturbances of the menopause, especially where insomnia is the chief and most distressing symptom. In these cases it brings on the periods and, at the same time, sleep.—*L'Art Médical*, No. 4, 1898.

IODINE IN THE ANASARCA OF HEART DISEASES.—Dr. Marc Jousset, of Paris, in a patient of the Hôpital St. Jacques, a homœopathic hospital of that

city, had under treatment Mme. L., aged seventy-two, an arthritic subject who habitually had enjoyed good health, but who for several years had noticed a sense of oppression on going up-stairs and in walking fast, and had gradually contracted a dry arthritis of both knees and atrophy of the thighs. During the spring of 1896 the dyspnœa had increased, the heart-sounds were feeble and prolonged at the base; there was arrhythmia, the radial arteries were slightly indurated and the urine copious. Diagnosis: Generalized arterio-sclerosis with incipient heart disease. April 25th, the urine much diminished, the heart-beats weak, irregular, and frequent, with considerable dyspnœa, œdema of the ankles, and the first seizure of asystolia. Digitaline (crystallized), 3 to 15 gtts. a day. This drug controlled the asystolia, but the œdema continued to rise and reached the thighs, though several drugs, as apis 1x and  $\theta$ , calomel and thyroidine 3x were administered. July 10th, iodine 1x was given, at first 10 and then 30 gtts. a day. In four or five days vomiting supervened, and the drug was suspended for three days. After several days' use the vomiting reappeared, but the œdema had greatly diminished. It was then given in a day dose of 20 gtts. of the first dec. dil. The effect was very favorable, and by August 15th the œdema was wholly gone, and up to December 25th it did not reappear, or was but slight. Then another crisis of asystolia set in, but then neither iodine nor digitaline had any effect.—*L'Art Medical*, No. 3, 1898. Prof. Vierardt in a recent number of the *Wiener Medizinische Presse*—abstract in the *HAHNEMANNIAN MONTHLY*, May, 1898—speaks very favorably of the results which he had obtained with the iodides in arterio-sclerosis. Many writers regard such cases at bottom as due to a chronic interstitial nephritis. We all meet with them. Pereira, *Materia Medica and Therapeutics*, 1852, p. 403, mentions iodine, it having been used with considerable advantage in dropsy. M. Buisson, of Paris—*These de Paris*—quoted by Martin Solon—*Dictionnaire de Médecine et de Chirurgie Pratiques*, vol. x., p. 519, 1833—caused a passive anasarca to disappear promptly by rubbing on the tincture locally and administering it internally in doses of ten drops a day.

**TREATMENT OF CYSTITIS AND CATARRH OF THE BLADDER.**—At a recent meeting of the French Homœopathic Society this subject was discussed. Dr. Marc Jousset regards canth. and terebinth. as the chief drugs; canth. when there is pus and terebinth. when there is blood in the urine (senecio Trans.). Tarantula 12x and capsicum 1x are serviceable in vesical tenesmus, the former especially in nervous persons, and the latter when it is associated with anal tenesmus. Dulcamara  $\theta$  or 1x are often of use in vesical catarrh. Irrigation and instillation of a solution of argentic nitrate may be required. Dr. R. Chancercel has frequently employed capsicum in tenesmus vesicæ, really in a cystalgia. He used the sixth decimal solution. Dr. Hebert has seen a rapid amelioration from copaiva in chronic cystitis. Dr. Cartier has found cubeba 6x of service when the tenesmus follows urination, and canth. when it precedes. Eupatorium purpureum is indicated in cystic catarrhs of women during the menses. Nux vom. often cures the cystic irritation of arthritics. Dr. Leon Simon has found sarsaparilla to act in calculous and arthritic cystitis. Hamamelis is indicated in some cases of hæmaturia from varicosis of the vesical veins.—*Revue Homœopathique Française*, No. 2, vol. ix.

FRANK H. PRITCHARD, M.D.



# THE HAHNEMANNIAN MONTHLY.

---

SEPTEMBER, 1898.

---

HOMŒOPATHY: ITS ORIGIN, MEANING AND SCOPE.

BY PEMBERTON DUDLEY, M.D., PHILADELPHIA, PA.

(Read before the American Institute of Homœopathy, Omaha, June 23, 1898).

THE combination of Greek words used by Hahnemann to designate his newly-discovered method in therapeutics is translated by the lexicographers as signifying "likeness of condition, feeling, or suffering." Dr. Dudgeon tells us that "in its adjective form it is found in two places in the New Testament," in both of which it is rendered "like passions." Hahnemann defined it as the treatment of disease by a drug possessed of the power to produce, in the healthy, symptoms similar to those of the case to be treated. Possibly a strict regard for literary accuracy may suggest that the definition should express the idea of similar *diseases* rather than of similar symptoms. I am not sure but that Hahnemann's explanation of the *modus operandi* of the homœopathic remedy suggests the former idea more strongly than the latter; but the mode in which he applied his doctrine certainly forbids any other interpretation than the one proposed by him and accepted by all his disciples.

To assert that the simple formula "*Similia similibus curantur*" embraces the whole that is to be learned of the philoso-

phy of homœopathy, or implies all that is essential to its proper application, would be much like asserting that the dogma of the Atonement includes the whole body of Christian Doctrine. Once admit the *general* truth implied in the injunction "Similia similibus curentur," or expressed by the dogma "Similia similibus curantur" if you please, and we are immediately confronted by a whole series of problems which must be correctly answered before an uniformly wise and skilful employment of the new mode of therapeutics is possible. These problems do not relate merely to the topics collateral to homœopathy—drug-proving, attenuation, the chronic miasms, and the rest—they concern the great central doctrine of similars itself.

As a preliminary to this discussion let us admit that Hahnemann wrote "Curentur," and not "Curantur." What matters it? If the injunction "Let likes be treated by likes" means anything, it means that likes are curable by likes; otherwise the injunction would be absurd. It also means that this mode is either the *best*, or the *only*, method that can be employed successfully. For this reason I purpose to base this paper on the assumption that there exists in nature a law of cure, and that said law is properly—even though inadequately—expressed by the formula "Similars are cured by similars."

If we are considering a natural law, and not a mere mental conception, we shall be compelled to recognize in our formula three distinct factors, each of which suggests questions that will not down at our human bidding. These factors are: first, the *agent* by which the cure is accomplished; second, the *object* upon which the curative action is exerted; and third, the *cure* that is to be consummated. What is Nature's curative agent? What is Nature's curable condition? What is Nature's curative process? No human intelligence can answer these questions except by first interrogating Nature herself. Their consideration would require a volume rather than a brief essay, and I can, therefore, attempt their presentation only in the merest outline.

A. What is Nature's curative agent? Is it any substance, or any natural force, or any influence, having the power to evoke symptoms? If so, does this natural law restrict the *method* of evoking symptoms to some one particular way, or

does it embrace all possible methods of accomplishing this result? We know that all the imponderable and immaterial forces—heat, light, electricity, etc.—and many other influences—fear, joy, anger, etc.—have been known to manifest symptom-producing properties. Do they also exert curative energy when indicated under the Hahnemann method? Again, the substances known as “drugs” exert symptom-producing power in at least four different ways, namely: by their mechanical, physical, chemical, and (so-called) dynamic properties. Are all these properties concerned in cures effected under the therapeutic law of similars, or is only one of them; and if but one, then which one? Among the more careful thinkers of our profession the opinion prevails that the law of similars can be applied only by means of drugs, and only by means of their pharmaco-dynamic properties. I shall not offer any argument for or against this view, but would respectfully submit that conclusive demonstration of either the truth or falsity of the proposition remains yet to be made.

A second problem that presents itself in reference to the curative *agent* is: What importance does Nature attach to the physiological method by which its pathogenetic symptoms are produced? To illustrate: the symptom “increase of glandular action” may be brought about in at least three ways, namely: by stimulating the gland’s nerves, by dilating its vessels, or by augmenting the vital energy of its parenchyma—its own living substance. Each of these modes may be represented in our provings by a different drug. Does it make no difference which of them we select from the symptom? And if a proper discrimination be essential, then how can the discrimination be intelligently made unless the provings designate both the symptom and its physiological relations?

The writer believes it will yet appear that many of our most philosophical prescribers are to-day working largely on this basis, though under supreme difficulties, and are rapidly accepting the opinion that the practice of homœopathy is something more than a game of medical dominoes—the mere matching of symptom-notations.

Still another problem under this head has reference to the primary and secondary action of the curative agent. I very seriously regret our common misuse of these two terms, by



which they have been employed to designate the direct-action and counter-action of the drug. Properly speaking, the "primary action" of a drug is that which it exerts directly upon the part to which it holds specific affinity. Its "secondary action" is that which is induced by the primary disturbance and not by the drug. To illustrate: a drug may exert a specific action on the alimentary tract and on no other part. But the violence or persistence of the alimentary disorder, thus induced, may bring about disorder, with symptoms, in the nervous and vascular systems, and in other parts with which the suffering alimentary organs are in close physiological relation. We ought to adopt the nomenclature of the pathologists and designate the first of these disorders "primary" and the other "secondary"—remembering, at the same time, that each of these two disorders may present both direct and counter-symptoms. Now suppose a patient to present himself with the symptoms contained in the above-mentioned secondary group, and with no present or past symptoms of the primary group; does any intelligent homœopathist imagine for a moment that the drug capable of causing these symptoms in this roundabout way could homœopathically cure them? The whole conception is absurd. There has been much discussion of the relative value of the direct and counter-symptoms of our provings, but it is of far greater importance whether, in our provings, these true and real secondary symptoms shall be designated as such.

Finally, under this head: It has already been said that, according to the general view, the homœopathic agent accomplishes its curative function only through that property which Hahnemann denominated its "dynamis;" in other words, its power to modify the functions—that, and that only.

But what sort of functions? This term is used to designate several classes of phenomena essentially unlike each other, and these different classes of functions are by no means well defined in the medical mind. We study physiology too much as naturalists and too little as therapists. We classify the functions as "animal" and "vegetative"—a classification of very little use to the physician. If we should arrange them under the heads of "mechanical," "physical," "chemical" and "vital," how much easier it would be to learn the principles and methods of adapting treatment to disease and injuries! Or, suppose we

should classify them as, *first*, those by which the organism holds relationship with its environment—functions of external relation; *second*, those by which each part or organ contributes to the welfare of other parts or organs or to that of the body as a whole—functions of organic relation; *third*, those by which each part maintains its own anatomical and physiological perfection—functions of autonomism; or, if you prefer, metabolism; though I do not believe that metabolism designates the whole of those independent activities which occur in each ultimate anatomical element.

It would, in the opinion of the writer, be easy to show that the homœopathic agent does not act upon those functions which are properly termed mechanical, physical or chemical, but only upon those known as vital. Or, taking our second mode of classification, it can be demonstrated that the similar remedy acts only upon the autonomic functions—the independent vital activities of the human body. Hahnemann must have had this conception when he prepared his masterly description of the functions, affections and relations of the vital force. But let us not misunderstand ourselves. There can be no doubt that the homœopathic agent, through its power to affect the vital or autonomic functions, may also, and does, bring about restorative changes in the others. Just as the pathogenetic action of a drug may be primary and secondary, so also may its restorative action be.

In this limited paper there is small chance for argument; but one thought should be presented in support of the view that the homœopathic agent acts only upon the *activities* of the organism, and not upon its anatomical arrangement or its chemical composition. It has been argued that a change in the internal activity of a part—a protoplasmic molecule, for instance—is not conceivable except in connection with a change in its structure. Yet it is well known that such immaterial agents as heat, light, joy, anger or fear can and do affect these activities; and it is absolutely inconceivable that these agencies can, under any circumstances, produce modifications of the living molecule except by first changing its internal activities. Moreover it is a fact of peculiar interest to the homœopathist that many efficient curative agents are such as could not possibly enter into the composition of normal protoplasm—such, for in-

stance, as arsenic, mercury, etc.—yet have power to change disease to health. We may conceive the possibility that these substances might form some sort of chemical or physical combination with the protoplasmic molecule, but that such an abnormal and monstrous combination could cause and constitute a restoration of the normality (health) of the molecule is utterly outside the realm of intelligent belief. The whole view of molecular science, as held nowadays, favors the theory that homœopathic action is exerted only upon *function*—only upon *vital* function, and only upon *disordered* vital function. But I anticipate.

B. What is Nature's curable condition? From what has been already said, it follows that the curable conditions which the homœopathic remedy is capable of affecting are those which depend for their causation or continuance upon disorder of the vital activities, and that disorders otherwise maintained must be treated otherwise. Observation of the results of practice in the homœopathic profession will convince us that nearly all the cases requiring surgical treatment and nearly all the essentially incurable cases come under the latter class.

It is so easy for one writing on this subject to be misunderstood that we should here call attention to that large proportion of cases whose symptoms spring out of a combination of maintaining causes, mechanical, physical, chemical and vital, or out of a union of two or three of them. It is also a matter of frequent occurrence that a disorder of the vital activity is secondary to some non-vital condition or cause. We can readily perceive the difficulty of curing such cases with the unaided homœopathic remedy; but even here we can accomplish much by the restraining and corrective *tendency*—if you will permit the expression—of the accurately chosen medicament. Thus homœopathy supplies our safest, perhaps our most reliable, means of palliative treatment.

If it be true that many conditions of vital disorder are caused and maintained by incurable non-vital agencies, it is likewise true that many conditions of apparently mechanical or physical disease are caused and perpetuated by vital disorders that are altogether amenable to the curative potency of the homœopathic remedy. It is a huge mistake to suppose that all mechanical and physical diseases—as they are called—require



mechanical or physical treatment. Many of them are curable by the homœopathic drug, difficult though its selection may be. Give us such a *materia medica* as Hahnemann contemplated when he wrote Sections 106 and 144 of the *Organon*—a *materia medica* composed of drugs whose entire pathogenetic range and power are known, and from whose recorded symptomatology every mere conjecture, every mere supposition, and every mere assertion have been rigidly excluded—and *with such* a *materia medica*, give us a full understanding of the philosophy of the law of healing, and we shall soon see the narrowing of the domain of surgery and witness an increased confidence in the power and efficacy of the *similimum*.

C. What is Nature's curative process? In other words, what is that particular change which takes place under the force of the similar drug? Until we answer this question we shall not know exactly what the law of cure means. Judging from the literature of medicine, to cure means to cut and slash and tear and tie and crush and sew tissues, to correct displacements, to imprison a wayward bone or a wandering uterus, to chop off a diseased or injured limb, to murder a parasite, to set up and run a chemical laboratory in a man's stomach, to whip up a pair of good, reliable kidneys until they become well-nigh useless from overwork, to lash the intestines, to goad the liver, to prod the skin, to paralyze the nerves and narcotize the brain, and to do a score of things utterly unlike each other to a patient whose vital energies are such as to enable him to get away with his life. When men use the term "cure" they mean all these things. But when Nature declares that she cures similar diseases with similar drugs, what does *she* mean? What is a homœopathic cure?

The scientific way to reach a reply to this question is by observing the homœopathic cure and seeing what it is like and what are its phenomena. And we first observe that it is usually accomplished with a quantity of medicine so small as to exclude the supposition that its action can be mechanical, physical or chemical. Second, we note that when administered in proper quantities the drug produces no symptoms of its own, showing that it does not cure disease by causing disease, and that it does not restore health to one part by making another part sick. It demonstrates that the action of the drug is ex-

erted only upon the part and function disordered and upon no other part, and that its action is only corrective and not pathogenic. These phenomena, when carefully interpreted, also indicate that the curative action of the drug is always primary—never secondary.

We may sum up the points of this paper as follows :

1. The homœopathic drug acts alone by its "dynamic" properties.
2. Its action is exerted only upon disordered vital activities.
3. It cures by changing abnormal into normal activity.
4. It may bring about changes in functions not properly considered vital ; but it does this only indirectly.
5. The homœopathic action of a drug never produces functional disorder.
6. The domain or scope of homœopathy includes all groups of symptoms springing from disordered vital activities.
7. Its domain also embraces the *amelioration* of such groups of symptoms, even when their underlying vital disorder is caused and maintained by incurable, non-vital conditions.
8. Its curative domain does not include symptom groups caused and maintained *directly* by mechanical, physical or chemical derangements of the organism, except when said derangements are themselves maintained by disorder of the vital actions.

Mr. Chairman : This essay seems to its author like a very little attempt to accomplish a very immense task. As to the question "When may the homœopathic practitioner resort to unhomœopathic methods of prescribing," I think the above statement of the scope of homœopathic influence is a sufficient answer. Aside from such a consideration, it will depend upon the breadth and intensity of the physician's belief in the superiority of the homœopathic over other methods, upon his intelligence, and upon his conscientiousness. I cannot be the judge of other men's conduct, neither can I undertake to make a peace between my professional brother and his conscience. I have troubles of my own.

---

THE MORTALITY OF THE VARIOUS OPERATIONS FOR FIBROID TUMORS OF THE UTERUS. (Weill.)—The writer reviews the various methods employed by recent operators and estimates their mortality as follows: Supra-vaginal amputation, extra-peritoneal method at first 18 per cent., then 13 per cent., and finally 8 per cent. Intra-peritoneal method 8-10 per cent. Retro-peritoneal method 5.6 per cent. Total abdominal extirpation 6.2 per cent. Vaginal total extirpation 2.5 per cent. and then 1.8 per cent. The French tend to operate without delay, the earlier the better. The Germans tend to operate later, and only when threatening symptoms arise.—*Centralblatt für Gynäkologie*, No. 20, 1898.

## NUTRITION.

BY JOSEPH PETTEE COBB, M.D., CHICAGO, ILL.

(Read before The American Institute of Homœopathy, Omaha, June 28, 1898.)

## Introductory Paper to Report of Section in Pædology.

IN selecting Nutrition, and the disorders dependent in part upon faulty nutrition, as the subject to be presented by this section, it has not been my expectation that anything new or wonderful would be evolved from this meeting; on the contrary, the subject was selected because it is one concerning which a great deal of exact information is at our hand, because by a proper and timely use of such information we can avert the larger part of ailments from which children suffer, and because a large part of the profession seem to have overlooked the importance of this subject in their admiration and study of the wonderful advances in surgery and pathology.

Nutrition or assimilation, in a wide sense of the word, is probably the most universal and characteristic property of animal existence. By this term we designate that series of changes through which dead matter is received into the structure of living substance. The term in its broadest sense may be used to cover the subsidiary process of digestion, respiration, absorption and excretion, through which food material and oxygen are prepared for living molecules and waste products of activity are removed from the organism.

It is necessary that the animal body should be supplied with food in order that its natural functions may go on without interruption; the waste of tissues by reason of work must be repaired; potential energy must be stored up to provide for the various kinds of tissue work, viz., motion, heat production, nerve force and metabolic activities. All of these purposes must be effected without undue waste, without unduly increasing the output, and without unduly taxing the constructive machinery.

That the study and proper regulation of the food to supply nutrition in the most favorable manner for these various pur-



poses in adult life is important cannot be questioned. That it often means to the infant and child its possibility of existence, and always its future capabilities, is not so universally appreciated.

The average weight of a babe at birth is approximately seven pounds; the baby who develops only at the average rate must double this weight in four months and must treble this weight in twelve months. This increased weight, startling as it is when compared with any relative growths in the adult, does not mean simply adding adipose tissue and storing up fuel for consumption. It means development of new tissues, reorganization of embryonic tissues, and the development of organs for new functions.

At birth the small intestine is only nine feet, five inches long, while during the first two months it adds about four feet to its length. The capacity of the child's stomach at birth is but a single ounce. During the first year of life this capacity is normally increased from eight to tenfold.

In the central nervous system the tissue has, to a large extent, to be made over, the foetal nervous tissue not having the capabilities for extensive work, being largely of an embryonic type. The changes in the osseous system and the length of time required for the perfection of its development are familiar to you all, and need only mention to be appreciated.

We might go on and enumerate many more striking demands for nutrition in the child not illustrated by any counterpart in the adult economy. Enough has been said, however, to emphasize in a general way the importance of faultless nutrition for the proper development of the child.

The influence of faulty nutrition as an etiological factor in scorbutus and rachitis will be discussed by writers in this section. The excessive tax put upon the eliminating organs by a faulty diet and the relationship of external protection to nutrition will also receive attention. Dyspeptic diarrhoea, one of the sequelæ of dietary errors, and proper substitute-feeding in infancy as a direct prophylactic measure, will be presented to you together.

With the aim of outlining the foundation for the special essays to be presented upon inanition, malnutrition, marasmus and anæmia, I desire to briefly call your attention to the various purposes of the different food-principles.

One of the best divisions of foods for a study of their uses is that given by Thompson in his valuable work on *Dietetics*, viz. :

I. Water; II. Salts; III. Proteids; IV. Starches; V. Sugars; VI. Fats and Oils.

In defining the uses of these different food-principles I shall quote freely from Thompson.

*The uses of water in the body :*

1. "It enters into the chemical composition of the tissues."
2. "It forms the chief ingredient of all the fluids of the body and maintains their proper degree of dilution."
3. "By moistening various surfaces of the body it prevents friction."
4. "It furnishes in the blood and lymph a fluid medium by which food may be taken to remote parts of the body and the waste material removed, thus promoting rapid tissue changes."
5. "It serves as a distributor of body heat."
6. "It regulates the body temperature by the physical processes of absorption and evaporation."

Water composes about 70 per cent. of the entire body-weight; the daily intake and output of water should be about  $\frac{1}{50}$  part of the body-weight. One of the most universal dietetic failings is a neglect to take enough water into the system for a proper maintenance of the physiological functions.

A deprivation of water shows its first effects in imperfect elimination; a continued deprivation changes the amount and character of the digestive secretions, thus impairing their capabilities. Imperfect nutrition, inability to rid the body of noxious compounds, the result of faulty digestion, and tissue katabolism and obstinate constipation, are common results in children fed upon too concentrated food and supplied with too small an amount of water.

Emaciation, changes in the blood and in the nervous tissues, will also surely follow from a continued deprivation.

An excessive use of water, a condition which often obtains in children fed upon diluted milks and various proprietary foods, increases the blood-pressure, forces the eliminating organs to do an excessive amount of work which may, in the kidneys, result in an alteration of their structure, and weakens the digestive organs by over-distention. The shape of a two-

or three-months-old baby's stomach who is obliged to swallow eight or ten ounces of fluid to obtain sufficient food for one meal will be materially changed. A dependent diverticulum is formed by over-distention which at all times contains liquid and partially digested foods flavored with lactic acid, butyric acid, and other irritating products of imperfect digestion. Such a stomach never normally empties itself; more or less frequently it will revolt and empty upwards what it cannot pass through the pylorus.

*The uses of salts are :*

1. "To regulate the specific gravity of the blood and other fluids of the body."
2. "To regulate the chemical reaction of the blood and the various secretions and excretions."
3. "To prevent the tissues from disorganization and putrefaction."
4. "To control the rate of absorption by osmosis."
5. "To enter into the permanent composition of certain structures."
6. "To enable the blood to hold materials in solution."

An excess of salts may act as a local irritant to the gastric or intestinal mucous membrane; may modify the rate of absorption; may interfere with the nutritive and chemical processes of the blood and tissues. Certain salts in excess tend to cause the deposit of calculi and concretions.

Continued deprivation of salts is followed by signs of malnutrition and mental inactivity, and is one of the factors in the development of rachitis and scorbutus.

Proteids are also an absolute necessity, as they supply the material from which the new proteid tissue is made and the old proteid tissue is repaired. The most important constituent of living matter is the proteid part of its molecule, and this can only be supplied by proteid food. A prolonged deprivation of this food-principle would result in emaciation and starvation, even though all other food-principles were abundantly supplied. Proteids also have an important use in the production of energy; they are complex compounds; they contain a large amount of potential energy, much of which is utilized in tissue metabolism.

The tendency in this country, however, is toward a dispro-



portionately large amount of proteid food, which taxes the eliminating organs by requiring them to excrete, in addition to the normal waste, a large amount of proteid derivatives which have served no purpose in the animal economy. This means excessive work for the liver and kidneys, and is recognized as one of the common causes of all forms of lithiasis.

There are on the market many food-compounds recommended as milk substitutes which are composed in part of proteid meat extracts and derivatives; they differ in their structure and behavior from milk proteids, and seriously tax an infant's digestive and eliminating organs. Under their use the fæces become more bulky, of a drier consistency, gluey in character, and by their odor give evidence of decomposition of undigested material. The urine becomes loaded with amorphous urates, uric acid and abnormal peptone derivatives; a catarrhal condition of the bladder, with its distressing symptoms, often follows; the skin loses its clear, smooth surface, becomes roughened, or even eczematous. The child is irritable, a poor sleeper, and subject to catarrhal inflammations.

I have seen all of this train of symptoms vanish where the child has been put upon a properly modified diet. During the first year of life the proteid element of food should come exclusively from milk; during the second year the proteid element of cereal foods can be well digested; but the proteids of meat should not be used before the child is three years old.

*Starches and Sugars.*—Their chief physiological value lies in the fact that they can be destroyed in the body, and by their destruction liberate energy. The energy of muscular work and of heat comes most easily and cheaply from the oxidization of carbohydrates. Seven of the thirteen per cent. of solids in milk consist of carbohydrates.

In preparing a substitute for mother's milk we must bear in mind that an infant who requires 50 per cent. of its solid food of this character can only use it to an advantage in one form, viz., sugar of milk.

*The uses of fats in the body are:*

1. "To furnish energy for the development of heat."
2. "To supply force."
3. "To serve as a covering and protection in the body."

4. "To lubricate and make more plastic various structures in the body."

5. "To spare the tissues from disintegration."

6. "To serve for the storage of energy."

About one-fifth of the body-weight is composed of fat; a large part of this is derived from carbohydrates, but some of it comes directly from fat in the food.

Its importance can be estimated by referring again to the composition of milk, where we find that one-third of the total solids are fat.

Chemical examination of the *faeces* demonstrates that in a child fed upon normal milk nearly one-half of the fat is not digested, but serves as a lubricant for the bowel in its work. Human milk has been found to be more often deficient in fat than in any other ingredient. Constipation is frequently the first sign of a deficiency of cream; the addition of cream to the baby's diet is at such times its best remedy.

Again, in early infancy a sudden demand is made for a new physiological activity; up to birth, potential energy has been converted into heat only to a minor extent; but with a separate existence this becomes an important function. Cream, next to sugar, is the source from which the infantile organism can most easily and cheaply obtain it.

The points I wish to make are that

1. A child's food has more varied and more lasting purposes to fulfil than has an adult's.

2. That good health and proper development require certain exactness in the relative and exact amount of different food-principles.

3. That as milk, whether human or bovine, is not always what it should be, it often requires to be modified or supplemented, to furnish the infant an economical and sufficient nutrition.

4. That the same care should be given the diet after as during the first year of life.

---

EAR MUSCLES OF ACCOMMODATION.—Dr. Rumbold, Sr., says that the function of the middle-ear muscles are to select and amplify such sounds as the listener desires to hear most distinctly, making it appear that the ears have muscles of accommodation quite analogous to those of the eyes.

## THE TREATMENT OF PNEUMONIA.

BY GEORGE FREDERICK LAIDLAW, M.D., NEW YORK CITY.

(Read before the Homœopathic Medical Society of the County of New York, June, 1898.)

I SHALL consider pneumonia as that inflammatory process which affects the air vesicles or the true lung tissue. Assuming that you need no reminder of the diagnosis and the nature of the disease, I will confine these remarks to the treatment of pneumonia, and in so doing will disregard the various types of croupous and catarrhal, secondary, septic, and so on, because, in the present state of our therapeutics, no useful modification of treatment can be based on the particular type of pneumonia present. It may not be amiss, however, to refer to the frequency with which pneumonia is overlooked, especially at the extremes of life, infancy and old age. A slight cough, disordered stomach and drowsiness may be the only signs of the development of a pneumonia that in a few days will make irreparable inroads upon the lung.

I will also assume that the physician is aware of the fact that there is such a disease as "abortive pneumonia," in which the symptoms disappear rapidly on the second or third day, and that he will not regard all such cases as brilliant cures.

In the care of the patient, the first necessity is to send him to bed, and the next is to obtain a good nurse. A nurse is necessary because the patient must usually be kept absolutely in bed. If he leaves his warm bed to get a drink of water or to go to the closet he runs great risk of being chilled, and a chilling during the course of a pneumonia is a dangerous occurrence. I prefer a trained nurse for two reasons: first, because a temperature, pulse and breathing record is of value in judging the progress of the disease and the effects of remedies; secondly, because in pneumonia there is apt to be sudden necessity for stimulants, and these are best intrusted to skilled hands and trained judgment.

In the treatment of pneumonia the second necessity is to care for the alimentary canal. In a disease where recovery depends so much upon the power of the body to nourish itself



and to combat toxins, the digestive organs must be kept in the best possible condition. Now it is a fact that in many patients the digestive tract is not habitually in its best condition. If constipation exists it should be relieved by a mild purgative or enema. Pneumonia is a toxæmia, and of all the bodily conditions that favor toxæmia constipation is the most frequent and the most readily overcome. Large enemata of warm water are especially serviceable, as they cause free excretion of urine and consequent improved elimination of waste material and toxins. Digestion, absorption, assimilation and peristalsis are carried on more actively when the lower bowel is emptied of its contents. In the administration of food the condition of the patient's stomach must be considered, and his usual habits of eating. I usually think it best to consider the prejudices or tastes of the patient in ordering the diet. Liquid or semi-liquid food in small amount at short intervals is the best general rule.

Having put the patient to bed and arranged for the nursing and the diet, the employment of local applications is the next topic for consideration.

As to local applications, we have the cold coil, the ice-bag, the poultice, the oiled-silk and cotton-batting jacket, the blister, the wet or dry cup, the mustard-plaster, iodine and guaiacol. After considerable experience with hot and sweating dressings, I am convinced that efficient warmth and protection can be obtained by putting on a woolen undershirt, over this the usual night-dress, and keeping the patient in bed. This dressing does not interfere with any local applications that may be deemed necessary, nor with further examination of the chest, as, for instance, when a second physician is called in consultation.

I usually paint the affected side of the chest with a weak tincture of iodine, repeating the procedure daily, or omitting a day now and then if the skin becomes sore. The object of the iodine is not to blister nor to obtain counter-irritation, for the solution is too weak to produce these effects. The aim is to saturate the tissues with iodine. Iodine is an excellent anti-phlogistic, and it has an especial affinity for the lung tissue. When it is given by the stomach it is apt to prove too irritating, but when applied to the skin it is readily absorbed and absolutely harmless.

If pain is present, something must usually be done to relieve it. For this purpose many physicians resort to morphine, and this practice is recommended in all standard text-books of the allopathic school. This practice I must condemn absolutely. If there is one drug more than another that is dangerous in pneumonia, that drug is morphine in narcotic doses. Pneumonia is essentially a narcotic disease. It kills by congesting and paralyzing the respiratory centre in the spinal cord. The action of morphine is similar, congesting and paralyzing the respiratory centre, and I am satisfied that many a patient to whom morphine is given to relieve the pain or cough of pneumonia sleeps on into the deadly narcosis, the end of which is death.

Personally, to relieve the pain in pneumonia I depend partly upon bryonia, spigelia, or other remedy, but more especially upon a method of manipulating the chest that was taught me in 1894 by the late Dr. Orrick Metcalf, of Natchez, Mississippi. This method consists in the kneading and stroking of the intercostal or overlying muscles, the costal cartilages or ribs in the neighborhood of the affected area. Somewhere in these localities will be found points of exquisite tenderness. After gentle manipulation of these points it is surprising to note the ease and comfort with which the patient can make even deep respiration.

Next comes the selection of the remedy—and here there is advice to suit all tastes, ranging from bleeding and massive doses of digitalis and strychnine to simple expectant treatment. Routine treatments for pneumonia are almost as numerous as the specific remedies for tuberculosis, and these are becoming as countless as the sands of the sea.

To my mind, the only routine that is of value is the routine resort to the homœopathic materia medica and the selection of a remedy according to the totality of the symptoms. As the surgeon reflects with pride on the success of an operation that was possible only to the hand made skillful by long training, so can the physician who honestly uses his materia medica revert proudly to many a cure that was only possible to a mind made skillful by long practice and honest labor in the field of materia medica. The homœopathic practice is a difficult one; it demands from its devotees much time and study; its diffi-

culties repel many; but to him who masters its secrets the rewards are priceless.

In pneumonia more than any other disease, except cholera, the superiority of homœopathic over allopathic treatment has been striking. In his book, *The Fallacies of Homœopathy*,\* the distinguished Dr. Routh, speaking of pneumonia, complains that "this is the disease which of all others has made the most perverts to homœopathy." The success of the homœopath in the treatment of pneumonia has been admitted by other allopathic writers, among them Sir John Forbes,† editor of the influential *British and Foreign Medical Review*, Sir W. R. Wilde, of Dublin,‡ and Dr. Wilson Fox.§ An explanation of why these distinguished gentlemen did not adopt such a successful treatment and give their patients the benefit of it is not forthcoming.

Successful as the homœopath has been, his death-rate still falls between 3 and 7 per cent. The question has come to me, as it must come to all, how we can save some of this 3 to 7 per cent. I will proceed to outline the methods that I have adopted with this end in view.

I think that many of you will agree with me in the statement that, in the practice of medicine, there are conditions that are better cured in other ways than by the homœopathic method. In relation to the present subject, the treatment of pneumonia, I can only insist upon the truth of that which I have already said in this Society, and that which I will continue to say as long as I have the privilege of speech amongst you, that the remedy homœopathic to the totality of the symptoms is not always the best remedy for the patient. The homœopathic totality is a mighty power in the cure of disease, but there are conditions in which it is surpassed by more specific medication; and I hold that those teachers of homœopathy

---

\* London, 1852, p. 47.

† *Homœopathy, Allopathy, and Young Physic*, *British and Foreign Medical Review*, 1846, vol. xxi, p. 243.

‡ *Austria, Its Literary, Scientific, and Medical Institutions*, Dublin, 1843, p. 277. "I am bound to say that the cases I saw treated by homœopathy in the Vienna Hospital were fully as acute and virulent as those that have come under my observation elsewhere, and the statistics show that the mortality is much less than in the other hospitals of the city."

§ *Reynolds' System of Medicine*, American edition, vol. ii., p. 209.



who ignore this fact are preparing our students very imperfectly for the many problems and emergencies of the practice of medicine.

In pneumonia, there are two groups of symptoms that assume especial importance by reason of their gravity; these are the symptoms of the heart and the symptoms of the brain.

When either of these symptom-groups become prominent, or when it is apparent that the symptomatic remedy is not controlling them within the limits of safety, my experience inclines me to direct my treatment especially to these symptoms in preference to the totality. The pure symptomatologist may urge that the totality will always cover the especial symptom-group. I do not find it so.

Of these two important symptom-groups, those of the heart and those of the brain, my first care is the heart.

If the pulse is full, regular and of moderate speed, if the heart-beat is practically normal and no pericarditis developing, the heart will require no especial attention at that time. If, on the other hand, the pulse is weak, irregular or extremely rapid, that pulse in itself indicates danger, and the conditions producing the pulse must receive especial attention. Digitalis, nitroglycerin, gelsemium, cactus, strychnine and coca are here of great value; and every physician, homœopath or not, should be familiar with the details of their use and the results that can be obtained by their employment.

My second care is for the brain. A clear mind that is wide-awake in the day and that sleeps quietly at night is of good import. There are two mental conditions apt to be troublesome in pneumonia; the one, wakefulness, alarms the patient; the other, persistent drowsiness, alarms the doctor. Both phenomena result from one of two causes: either the presence in the nerve-centres of blood loaded with the toxins of pneumonia, or a localized meningitis. The poisonous effect of the pneumonic toxin is usually intensified by the products of urinary suppression or other imperfectly eliminated excretions. The action of the poisons is at first to irritate, causing wakefulness; then, owing to the increase in the quantity of the toxins or to the reactionary congestion, the nerve-centres are overpowered, and a condition of stupor, with delirium, appears. The stupor is undoubtedly deepened by the non-aeration of the blood that

is associated with closure of a large pulmonary area by the pneumonic exudate.

To my mind, this sleepy state of pneumonia is a condition of danger. The physician should watch for its development and treat it promptly. In the treatment there are several factors to consider. We have a condition that is partly toxæmia, partly insufficient aeration of the blood. Our best treatment of the toxæmia is active elimination of the poisons, together with the prompt administration of an antidote. As the antidote to the toxins of pneumonia is as yet unknown, we must depend upon elimination. The grand eliminating organs are the liver, the intestinal tract, the kidneys, the lung and the skin.

As far as the liver and intestines are concerned, the so-called cholagogue purgatives meet the indications; and while doubt has recently been thrown upon the actual cholagogue value of calomel, aloes and colocynth, leptandra and podophyllum, there can be no doubt in the mind of anyone who has experienced the head-clearing influence of these drugs that their action on the organs of elimination, whatever it be, is sufficient for practical purposes.

The eliminating action of the skin is best obtained by a ten-minute immersion in a bath of a temperature of 105 degrees (for children 102 degrees are sufficient), and then wrapping in blankets for half an hour. This bathing is a violation of our primary rule of rest in bed. If carefully performed, and if the water be as hot as here directed, there is practically no danger of chilling; and the restful sleep, the gradually falling temperature, steadying pulse and clearing mind that follow the bath indicate the skin to be a valuable organ of elimination in the toxæmia of pneumonia. Then I recommend the bath only in cases in which elimination is markedly deficient, and thus in itself is a danger to life. It would be folly to bathe a patient who was already doing well. Sponging the surface of the body or a simple sweating are also useful measures in promoting elimination.

Elimination by the kidneys is increased by the measures directed to the skin, and also by digitalis, gelsemium and other drugs that steady and reinforce the pulsations of the heart.

The fourth organ of elimination is the lung, and here I can again recommend Dr. Metcalf's treatment by manipulation that I have already described when speaking of the relief of pain. By the manipulation of the sensitive points about the chest, the patient is enabled to breathe more deeply, thus fulfilling the double indication of increasing the supply of oxygen to the blood and also increasing the elimination of noxious materials that are carried off by the current of expiration. A remarkable feature of this manipulative treatment is the free expectoration that frequently ensues, to the great advantage of the patient. To obtain the full benefit of this treatment, it must be employed in the early stage of the disease, though I have seen it successfully employed in advanced and apparently desperate cases. Manipulation in pneumonia is a life-saving measure. The same may be said of inhalations of oxygen gas, which often relieve dyspnœa, cough and wakefulness.

Of the drugs that are applicable to the stupor of pneumonia, I have seen distinct benefit from *chelidonium*, *carduus mariae*, *sanguinaria*, *bryonia*, *phosphorus* and *opium*.

I do not know what connection there may be between the liver and the pneumonias that commence in the right lower lobe, but I incline to the ancient opinion that such a pneumonia may be secondary to a liver disorder. At any rate, in such a pneumonia I have often seen good results from such pronounced liver drugs as *carduus* and *chelidonium*. The pneumonias to which these drugs have proved especially applicable were irregular, and presented no grave heart symptoms. I am equally certain that some pneumonias of the left lower lobe are related to the spleen, and are more readily cured by *ceanothus*, *squilla* and *carduus* than by the *similimum*.

In speaking of the toxæmia of pneumonia, I have said that we know no antidote. Professors de Renzi and Pane have recently recorded a series of cases treated by injections of a pneumonic antitoxin, and their results have been verified by several observers in this country; but these results, a death-rate of 10 to 15 per cent., are no better than we can already obtain with less dangerous measures. In fact, in pneumonia, we homœopaths have a death-rate of only 3 to 7 per cent.

While, as yet, we have no reliable antidote to the pneumonia toxins, no antitoxin, we approximate this state by possess-



ing a substance which is credited with the power of aiding the patient's blood to form its own antitoxin. I refer to proto-nuclein.

I have no wish to rival our enthusiastic colleague in Paterson, New Jersey, but I cannot discuss the treatment of pneumonia without referring to the high opinion that I have formed of the power of this substance in septic conditions. It is of value especially where the temperature runs high, without other marked phenomena. Five grains every three to six hours will cause a temporary increase in the temperature, followed by a gradual decline to a safe level.

The question of stimulants is an important one. In all pneumonia cases there is apt to come a time when the pulse intermits, the extremities become cold, and collapse is imminent. In such a condition alcohol, in the forms of whiskey, brandy, gin or rum, is the best remedy. The other heart stimulants are useful here. Now, in cases in which the first day of the pneumonia can be recognized, it will be noticed that the flagging of the heart usually commences on the ninth or tenth day, that is, about the crisis. This phenomenon is also observed in cases in which no marked crisis occurs. It seems to me to be a wise action to forestall this period of heart depression by commencing the alcohol just before the expected period. I therefore follow with advantage the rule formulated by my father, Dr. A. H. Laidlaw, to commence stimulants on the eighth day and continue to the twelfth, unless the condition of the case should demand an earlier resort to them or a more protracted administration.

I know of no specific treatment for pneumonia. I have not much faith in ferrum phos. and kali muriaticum in croupous pneumonia; their action has not impressed me as sufficiently profound. Of all the routines, I think the strychnine treatment the best, but believe that the well-informed physician can surpass even the strychnine routine in a given number of cases, because the treatment of the well-informed physician is elastic and adapted to the individual, which is not the case with the strychnine routine. I must again declare my confidence in the carefully individualized remedy. Time and again I have seen the thirtieth or the two hundredth potency gradually lift the darkening cloud that seemed to be closing in around a human

life; but this work is not done by a careless guess. It requires a careful review of the materia medica in relation to that case, irrespective of the drug that cured the last patient.

*Veratrum viride* is useful as a general reducer of pulse and temperature, and also cleans off a coated tongue nicely. *Aconite* sustains its old reputation when thirst, restlessness and anxiety are prominent symptoms.

This completes my summary of the measures useful in the treatment of pneumonia. They are numerous, and are drawn from diverse fields. Some measures will be found useful in one case but inapplicable in another, and I am sure that the methods of treatment outlined are no more numerous than the resources of a well-informed physician should be, and no more diverse than the diverse forms of this protean disease require.

---

## MODERN TREATMENT OF EXTERNAL EYE DISEASE.

BY C. GURNEE FELLOWS, M.D., CHICAGO, ILL.

(Read before the American Institute of Homœopathy, June 25, 1898.)

IN discussing the modern treatment of external eye diseases I wish especially to bring forward those things which recent developments have proven to be efficacious. There will not be time to discuss those methods which, though classical, are now discarded as harmful. One would hardly recognize the treatment of many diseases as in any way related to the same subject discussed in text-books a few years old, and in no line of work is this change more rapid than in the department of ophthalmology.

Ophthalmologists of all schools are learning from experience that many of the ideas formerly advanced are erroneous, and that harsher treatments, stronger medicines, counter-irritants, etc., delay rather than promote a cure. The indiscriminate use of strong solutions of nitrate of silver, the old blue stone, alum, etc., are being relegated to the rear; on the other hand, many new preparations which are extolled upon their first appearance do not prove, after longer acquaintance with them, to be

of permanent value. I wish, however, to bring up for discussion some of the newer medicaments, as well as the older, and those which have proven themselves to be of value, and are being placed in our every day armamentarium. As an example, the classical use of nitrate of silver in a 10-grain solution, after the manner of Credè, has still many warm adherents, but it seems from the usage of recent years that the strength of the solution has been reduced, and simple antiseptics, which are certainly harmless, answer every purpose of prophylaxis in the ophthalmia of new-born children. It is probable that the flushing of the conjunctiva prevents the continuation of the disease by washing away the germs rather than the actual killing of them by toxic agents, and surely in our school there is no reason why we should not use the milder means locally, together with the internal, for the best results.

One of the new and valuable drugs used in ophthalmology is holocain, which is quickly absorbed, produces anæsthesia in a few seconds without drying the cornea, dilating the pupil, or paralyzing the power of accommodation, advantages not possessed by cocaine. It may be used in weak solutions, 1 per cent., or even half of 1 per cent. answering every purpose. It is especially valuable in removing foreign bodies and other light operations of short duration, although applicable to other operations, including cataract.

The extract of suprarenal capsule is valuable for the following reasons: Its physiological effect is to contract the arterioles. Its main use is to increase the action of cocaine by locking up the latter drug in the tissues and thereby preventing hæmorrhage. So far its use has not been followed by any constitutional disturbances. The lack of hæmorrhage, the ischæmia which it produces, and its prompt action make it exceedingly valuable in operations upon the external parts of the eye.

Subconjunctival injections of bichloride solutions, much vaunted at first, have proven to be of permanent value at certain stages of the treatment of ocular diseases. It is possible, however, that injections of the solution of chloride of sodium or boracic acid may be equally useful.

Formaline, a 40 per cent. of formaldehyde, is an antiseptic of great worth, as it prevents putrefaction and is a tissue preserver, though not toxic. It diffuses itself rapidly through the



tissues, does not coagulate albumin, as does the bichloride, and is therefore a very useful antiseptic in both acute and chronic inflammation of the conjunctiva, in corneal ulcers, both simple and infecting, in solutions of 1 to 1000 or weaker. It is also a good antiseptic for the preparation of instruments, as it does not dull their edges.

In inflammatory troubles, where the tendency is toward suppuration, the application that can take the place of the old-fashioned poultice has been greatly sought after, and it seems to have been found in antiphlogistine. It has the power of aborting the process of suppuration if applied sufficiently early. It quickly and easily centres the suppurative process, if inevitable, preparatory to a surgical opening. It relieves the pain and tension by absorbing moisture, and it loses its power only after having itself become dry. I have had good success with it in treatment of threatened abscess of the lids.

Blood serum, or some of its equivalents, in the form of prepared foods, has been extensively used in general surgery, particularly in ulcers. The feeding of the cornea, which is very scantily supplied with nutriment, especially in inflammatory conditions, is essential to the restoration of the healthy condition, and when the bloodvessels are already loaded to their capacity, and the lymphatics are surcharged with *débris*, the cornea can derive but little nutriment from the natural channels. It is in such cases when ulceration is found far advanced that the direct application of bovine, dropped in its undiluted state directly upon the cornea, exerts a powerful influence toward arresting the disease and bringing the cornea back to its healthy state. I could cite some interesting cases, the happy termination of which I believe due to the use of blood serum.

Fluoresceine in a 1 per cent. solution is not of so much value from its therapeutic as from its diagnostic standpoint. When applied to the healthy cornea it leaves no trace behind, but the slightest roughness or breaking of the epithelium by a foreign body, injuries, or inflammatory disturbances, will be immediately detected by the staining of these points a greenish-yellow in color, and thereby outlining them accurately for the eye of the attending surgeon.

Massage, both general and local, is a subject which has received a great deal of attention within the last few years, but

particularly as applied to the general system. It is, however, as applicable to the eye as to any other individual organ. It is quite possible that the massage itself by increasing the blood-supply increases the action of the lymphatics, the main virtue of its therapeutic effect. It may be combined with medicated substances which will assist in obtaining the desired results. Massage is particularly indicated in diseases of the conjunctiva. In the subacute and chronic forms of conjunctivitis, especially of the papillary form, and in trachoma, the application of massage, together with a powder of boric acid, calomel, or ointments of yellow oxide of mercury, tannic acid, or whatever medicament is indicated, will be followed by satisfactory results. Some years ago I saw many cases of simple trachoma in the acute form treated by massage applied directly to the inverted lids, upon which a copious application of pure boric acid had been made, and the results appeared to be eminently satisfactory. Massage, when thus applied, should be made directly to the diseased tissue and not indirectly through the lid. Use is also made of direct massage in the treatment of corneal opacities, but in this instance by means of a hard rubber spoon and with the addition of some stimulating ointment. Corneal nourishment has thus been secured, absorption improved, vascularity increased, and the lymphatic channels stimulated. While speaking of trachoma I will simply mention the treatment recently adopted for the proliferating or hypertrophic form by the use of roller forceps or some modification of them for the purpose of expression.

Heat and cold are two agents, which, though always at hand, and so simple that they should be thoroughly understood, have not received the attention at the hands of all physicians that they deserve. The temperature of the eye varies in health and disease as does that of other organs of the body. Up to the present time we have not been able to detect the variations of temperature to an accurate degree, but Galezowski has recently invented a practical thermometer by which he hopes to be better enabled to detect the variations of temperature. Heat and cold can raise and lower the temperature if applied under proper conditions. Cold lowers the temperature by contracting the bloodvessels, and heat raises the temperature by dilating them. Cold limits the exudation in inflammatory condi-

tions, while heat aids by absorbing exudation and promoting nourishment by stimulation. Continuous application of either agent is necessary until the effect is produced, at least fifteen minutes being the average time for therapeutic purposes. Cold dry applications are advised, made by the use of the ice-bag or ice-water run through Leiter's coil, while cold moist applications are made by gauze taken directly from blocks of ice. Dry heat can be obtained by means of a hot-water bag or hot water through a Leiter's coil, and hot moist application by compresses wrung out of hot water, or by means of steam and vapors through an atomizer modified to suit the purpose. Traumatic conditions and iritis frequently demand ice in the early progressive stages, but in the later stages with involvement of the cornea heat is the more efficacious. Heat promotes the absorption of drugs, as instanced in iritis; when adhesions have taken place and atropine fails to act it may be greatly augmented by the application of heat. In the early stages of pannus cold is allowable, but when vascularity appears heat is to be preferred. For the relief of pain, particularly neuralgic in character, heat is as a rule to be preferred to cold.

There is a therapeutic use of bandages. At times the cornea, when about to rupture, needs support. Following operations or trauma, bandages are used to hold the eye immovable, and are therefore used for compression. Their applicability as therapeutic agents can hardly be questioned, but their absence is just as necessary in corneal or conjunctival troubles in order to allow better drainage, contact of air to the diseased parts, to allow of motion, etc.; and in these conditions, when light must be diminished, the use of colored glasses is allowable. But I believe that the prescription of colored glasses by the laity is often injurious, for the eye in a healthy state is tolerant of light.

Electricity in almost all its forms may be useful in various diseases of the eye, but so far as external diseases are concerned the galvanic and faradic currents are not so commonly useful. The galvano-cautery is, however, a sheet-anchor in serpiginous or infecting ulcer, helping to cut short its progress.

Electrolysis has been used in combating trachoma, platinum knives having been commonly used; of late, however, copper electrolysis has been warmly advocated. In this connection I



can but refer to the great advantages to be derived, for the purpose of diagnosis, from the recent introduction of the Roentgen ray.

I would not have you believe that, after mentioning all of the foregoing methods of treatment local in character, these are the only means at our disposal. We do not advise the use of all of these methods all of the time, nor some of them all of the time, but some of them some of the time. It should not be possible to treat diseases of the eye without a thorough understanding and knowledge of the body as a whole, and it is advisable that all oculists should first be not only educated as physicians, but that they should have practiced general medicine for some years. The eye is part of the human body, and should neither be separated from it in health or disease, when it comes to the question of its treatment. Causes near or remote should be thoroughly understood, their co-relation and interdependence analyzed; and if a torpid liver, indigestion, renal insufficiency, or localized inflammation within the brain, be at fault and the cause of ocular disturbance, the oculist should know how to trace it and when to refer the patient.

His knowledge of exclusion should be as great as that of inclusion. But when the eye is at fault and needs attention it becomes his business to prescribe for the various dyscrasias, to recommend hygiene and sanitation, to have a knowledge of climate and its effect upon his patient, and then to select the remedy in accordance with the whole picture, covering the body from head to foot, and the best interests of his patients will be subserved.

---

PTOSIS AS A SYMPTOM IN ABSCESS OF THE TEMPORAL LOBE.—Steinbrügge reports the case of an abscess in the temporal lobe of the brain secondary to purulent otitis media, in which ptosis of the correspondent upper eyelid formed an interesting symptom.

This combination was first brought to the notice of the profession by Körner.

In the opinion of Steinbrügge the ptosis in this case was not due to a spasm of the orbicularis palpebrarum, but to a paresis or weakening of the innervation to the levator palpebrarum.

At any rate, as a corroborative symptom in this condition, ptosis is worthy of note.—*Deutsche Medicinische Wochenschrift*, 1897, No. 41.

A CLINICAL LECTURE ON VARIOUS FORMS OF STUPOR, UNCONSCIOUSNESS AND COMA, WITH THE DIFFERENTIAL DIAGNOSIS AND EMERGENCY TREATMENT.

BY WALTER SANDS MILLS, M.D., NEW YORK CITY.

(Delivered at the Metropolitan Hospital, February 23, 1898, to students of the New York Homœopathic and of the Women's Homœopathic Medical Colleges.)

A WEEK ago to-day there was brought into this hospital a man suffering from a slight paralysis of the right side, including the right side of the face. He was in a sort of stupor, but could be roused enough to answer questions with more or less intelligence. His history, so far as could be made out, was of a fall, followed by paralysis.

I saw him for the first time on the following day. At that time his face was flushed, and there was some temperature. The stupor was more marked; the face was drawn a little to the left side; there seemed to be paralysis of the right side of the body, and the speech was very thick. The urine was greatly diminished; enough was gotten, however, to test; evidence of kidney trouble was found. The muscles of the right arm seemed to offer some resistance; the muscles of the leg did likewise; so that trying for the patella reflex was unsatisfactory.

Here was a case for diagnosis and treatment, and it occurred to me that a discussion of it, with a talk on various forms of stupor, unconsciousness and coma, would be a very profitable way to spend one hour to-day. No matter what line of practice you may follow, you are liable to meet with such cases. Some of them will be patients of your own, many of them will be patients you have never seen before, and you will be called because you happen to be at hand when the emergency arises.

Taking the history of the case before me, I rapidly eliminated everything but apoplexy and uræmia. I was able to do this only because I had notes of the case for twenty-four hours to draw from. Without some history it is absolutely impossible in the majority of cases of unconsciousness to make a diagnosis. Concussion of the brain may cause unconsciousness;

various poisons may cause it; sometimes the sudden onset of an infectious disease will overpower the system to such an extent as to cause stupor or coma; unconsciousness may also appear later in the course of certain diseases, and we may have alcoholic coma. The treatment of these conditions varies according to the cause.

Ordinary syncope is characterized by a sudden loss of consciousness, weak pulse and extreme pallor. As a rule, unconsciousness lasts but a very few minutes, although I have seen cases where it lasted nearly an hour. When the patient recovers the mind is perfectly clear. During the attack there are no convulsive movements. So soon as we have those we have something more than syncope. Syncope may be caused by mental shock, by overwork, by bad air, or by anything that tends to disturb the circulation. All of you have probably seen persons faint in crowded places; perhaps some of you have fainted in the operating-room or in the dissecting-room.

Ordinarily, such simple remedies as *aromatic spirits of ammonia*, the *compound spirits of lavender* or *spirits of camphor*, administered by olfaction, with a sufficiency of fresh air, will revive the patient.

If fainting is a habit, that is, if the patient has frequent attacks of syncope, there is probably some constitutional reason for it which the physician should try to discover. In such cases the indicated remedy must be given and continued for a long time.

In epilepsy, following the convulsion or spasm, there is always a period of disturbed mentality. It may be stupor, it may be a complete unconsciousness. This form of stupor is distinguished by the preceding convulsion and by the more or less rapid return to a normal condition. For the emergency there is nothing to be done except to keep the patient from injuring himself. While acting ambulance-surgeon at the Brooklyn Homœopathic Hospital, some years ago, I was called to attend a letter-carrier who had been seized with an epileptic spasm while on his first trip. After he got over the convulsion I took him to the hospital, and it was four or five hours before he was able to tell his name or to remember where he lived. In this case I was assisted in my diagnosis by the bystanders who had seen the fit.



Some of the poisons might produce a gradual loss of consciousness with thickness of speech, as in the case under discussion. Irritant poisons would, however, leave some evidence about the mouth or fauces. Again, if taken in sufficient dose to produce as severe symptoms as these, they would speedily cause death. Of the narcotic poisons, some form of opium is the most commonly used. In opium poisoning there is no hemiplegia, the pupils are like pin-points, the breathing is stertorous; there may or may not be convulsions. When opium poisoning reaches the stage of coma the patient is going to die if prompt relief is not given. The drug in the stomach should be removed. Black coffee is the best "hurry-up" antidote. The patient must be kept awake at all hazards. It has been my good fortune to see but one case of opium poisoning, and that was intentionally produced by the physicians in charge of the case. The patient was a girl of nineteen, who had had one convulsion after another for forty-eight hours, and was in imminent danger of dying. All the remedies in the *materia medica* had been used without avail. Chloroform had been tried for hours; every time its use was stopped the convulsions returned. At length, in sheer desperation, half an ounce of opium tincture was administered by the rectum. In a short time the convulsions ceased and the patient began to show symptoms of opium poisoning. After another thirty-six hours of hard work in keeping our patient alive, we had the satisfaction of seeing her once more in her normal mental condition. This case occurred in the Ward's Island Hospital during my service as interne. The patient recovered from all her ailments when she rid herself of the effects of the opium.

I have seen several cases of complete alcoholic narcosis. Usually you can get a history of heavy drinking. If you find the patient unconscious and are without any data to go by, I know of no way in which a diagnosis can always be made. If you have the patient under your care for a few hours he may develop delirium tremens, he may recover consciousness, or he may die. If you know the case to be one of acute alcoholism, empty the stomach. *Nux vomica* is a good remedy in appreciable doses. One to ten drops of the tincture may be given. Black coffee is also efficacious. While an interne at Ward's Island and at Brooklyn I learned to use *avena sativa* for alco-

holics who were nervous but not delirious. It is an excellent nerve tonic after the acute stage of intoxication has worn off and before the patient has reached the stage of delirium. Of course alcohol is contraindicated in treating such cases. I refer to cases of alcoholic coma.

One or two cases of acute alcoholism that I have seen have presented some points of interest that it may be well to refer to. When liquor has been taken in large quantities we get first the stage of intoxication, then of stupor, and finally of coma. Coma is rarely reached unless the patient has imbibed a great deal in a very short space of time. I have seen one case of complete narcosis where the patient was in a state of collapse. The skin was bathed in a cold perspiration, the pulse was very rapid and so weak as scarcely to be felt, the lips were blue, the insensibility was profound. This condition lasted for several hours.

Another case was that of a man who had been found by the police in an unconscious condition. Police methods of resuscitation, pressure on the supra-orbital nerves and clubbing the soles of the feet, had no effect. The ambulance mixture of *aqua ammonia*, *capsicum tincture*, and *nux vomica tincture*, otherwise known as the "O! be joyful," elicited nothing but grunts. Careful examination detected no sign of injury. The breathing was not stertorous, the pupils were alike, the pulse was rapid but not weak. Taking everything into consideration, I made a diagnosis of acute alcoholism. After twelve hours this patient woke up in good condition, told us where he had been the night before, and so confirmed my diagnosis. As no alarming symptoms were present no treatment was given.

If your case is one of acute alcoholism, time will eliminate the poison. Nothing can be told by the odor of the breath, because a man who is drunk may injure himself or he may have a cerebral hæmorrhage, or a patient who is ill may have alcoholic stimulants administered to him.

In the case under discussion the patient was in a deeper stupor at the end of twenty-four hours than when he entered the hospital. That precludes acute alcoholism. In chronic alcoholism, after twenty-four hours we would not have stupor or coma, as in this case, but we would have delirium.

Sunstroke or heat prostration is also excluded in this case

because of the season. There are several points of differentiation that may be mentioned. In the first place, when heat overcomes a person the cerebral condition is most profound shortly after the attack. It is not a stupor so much as it is a coma. Insolation and acute alcoholism simulate each other closely, and it is not always easy to differentiate. In insolation the temperature is typically high; I have seen it as high as  $112^{\circ}$  in the axilla; whereas in alcoholism, in cases of unconsciousness, the typical temperature is subnormal. As preventive of sunstroke, Raue recommends *gelsemium*. During the acute attack he recommends effusions of lukewarm water in conjunction with such remedies as *glonoin*, *belladonna*, *amyl nitrate*, *camphor*, according to the indications. Cases vary immensely; we may have asthenic fever to deal with, with acute congestion, full pulse, and so on, or we may have directly the opposite—complete collapse. The treatment will accordingly vary.

Another condition that may for a short time confuse the diagnostician is a combination of syncope and hysteria. I have seen one such case, and presume I might class it with what Da Costa calls "Cerebral Hysteria." The patient was a young married woman of an hysterical character. She had a valvular trouble of the heart, was anæmic, and was addicted to frequent attacks of fainting. She was at a ball one night, and, as she was excessively fond of dancing, danced beyond her strength. I was also one of the guests, and had warned her early in the evening to be careful and not dance too much, but to no purpose. Late in the evening she was seized with an alarming attack of syncope; she regained consciousness only to have one attack after another, even fainting several times after we got her home and in bed. The next day—or the same day, rather, as it was breakfast-time before I left her—she developed a pseudo-paralysis of one hand and arm. The hand was apparently deformed, or at least it was deflected to one side, and was helpless. Unfortunately I have no notes of the case, as it occurred before I began my system of record-keeping. However, at the time I knew it to be of hysterical origin and was not alarmed, although the husband and relatives were. It passed away in a few days.

I have said that the sudden onset of an acute infectious dis-



case may produce stupor. I think that rarely occurs excepting in children. I have seen it but once. The patient was a girl of seventeen or eighteen months, and was in a stupor for twelve hours or more. It was a case of scarlet fever, as the subsequent developments showed. The patient recovered.

Where stupor or coma develops later on in an acute or chronic disease we, as a rule, have the history to aid us. Such patients have been ill and under treatment, and the unconsciousness develops gradually. Uræmic coma may be an exception to this. Sometimes patients will be well advanced in some form of nephritis without knowing it, and the uræmia will seize them unexpectedly while they are about.

This recalls one case vividly to mind. A man was seen staggering along the street one night about 9 o'clock, and was arrested and locked up. After an hour or so he called for a drink of water, and it was given him. About midnight the policeman on duty found the man apparently asleep, but breathing heavily. Not being able to rouse him an ambulance call was sent in, and I happened to be the attending surgeon. The sergeant at the desk explained the circumstances as detailed above. As I walked down the corridor of cells, and before I even saw the patient, I could hear the peculiar stertorous Cheyne-Stokes breathing, which I think is more typical of uræmia than of any other form of coma, and which if once heard can never be forgotten. I sent out for my stretcher, wrote out my diagnosis of uræmia, and made a hurry-trip back to the hospital. The patient died in about three hours, and my diagnosis of chronic nephritis was confirmed later at the autopsy table. No brain lesion was found.

The distinguishing points are not always marked enough to make a differential diagnosis. In uræmia, however, convulsions usually precede the coma; in apoplexy they usually come on after coma has developed. Again, in uræmia the tendency is for the temperature not to rise; in apoplexy there is an initial fall followed by a rapid rise. According to Da Costa, if the rise be continuous, or if the temperature does not again drop shortly after the rise, the outlook is bad. In uræmia we find a rapid pulse; in apoplexy the pulse is said to be slow. My experience does not agree with this latter statement, perhaps because the majority of cases of apoplexy that I have seen have been fatal.

Meningitis may be separated from apoplexy by the preceding history. I have never seen the former and so cannot give you any of the differential points at first hand.

There are certain changes that take place, usually in old people, diseases of the arteries and of the brain, that may produce symptoms similar to those of apoplexy. They may be the cause of a hæmorrhage into the brain late in their development.

Tumor of the brain may cause unconsciousness and hemiplegia, but here the change is more gradual and the patient is not so apt to be stricken suddenly as in apoplexy.

Abscess may also cause coma: first, by acting as a tumor; second, by rupture, when its symptoms are abruptly developed.

Diabetic coma is another form of coma that may be met with. According to various authorities the onset is gradual; first somnolency, then stupor, and finally coma. The history of the case will be almost a necessity to enable one to make a positive diagnosis. I have never seen a case, so far as I know.

Obstruction in the cerebral arteries is said to cause the nearest approach to an accurate picture of cerebral apoplexy. I am not aware that I have ever seen a case, but from my reading I should judge that a knowledge of the patient's previous history was of importance. Obstruction is caused by an embolism or by thrombosis. The results are exactly the same as in apoplexy, excepting that, as a rule, the symptoms develop more suddenly than in hæmorrhage. Embolism may be the result of valvular disease of the heart, or of various diseases of the blood-vessels. You can readily understand why the symptoms should appear suddenly. The blood-current is of sufficient speed to cause a given corpuscle to make a complete circuit from the heart through the body and back to the heart in about twenty seconds. It can be conceived that an embolus starting from any part of the body will, when brought to a standstill in one of the cerebral arteries, cause an abrupt change in the circulation of the part. On the other hand, a hæmorrhage, unless it be very great, will be apt to operate more slowly.

I am of the opinion that the case under discussion was one of hæmorrhage rather than of embolus, because, as you will learn when I read you the complete history, the symptoms were less abrupt than they would be in embolus.

I have seen one case of cerebral hæmorrhage due to arterio-sclerosis, caused by syphilis. This patient first developed slight difficulty in talking, followed in a few hours by a gradual loss of power in the right arm and leg. At the end of twelve hours there was complete loss of motor power of the right arm and leg and of the left side of the face. There was also aphasia and agraphia. The intelligence was to a certain extent dulled, although not very much. Everything that others said and did was understood by the patient. Sensory paralysis did not occur. The patient recovered enough to talk and write, and the motor powers were completely restored. There was always some paraphasia, the patient making a mistake in choosing words that are generally associated or contrasted in conversation. For instance, he would ask for bread when he wanted butter; would say funeral when he meant wedding, and so on. The arterial degeneration was not cured, and a second hæmorrhage killed the patient. The second hæmorrhage caused paralysis of the side that was well and convulsions of the side first affected.

I believe that I have considered the principal sources of stupor or coma caused by disease; it remains to say a few words about stupor or coma caused by traumatism. If you are called in in an emergency to see a patient in a stupor or in a state of coma, the friends or relatives will not stop to consider whether you are a physician, a surgeon or a specialist. They will call you as a doctor, and as such they will expect you to help them. In any event a diagnosis cannot be accurately made without a consideration of these traumatic causes.

In the first place, we may have shock. Wyeth defines it as "a condition of collapse resulting from physical injury or mental emotion (one or both), whereby the functions of the nerve-centres are more or less completely suspended." The patient is in a state of collapse. The skin is clammy, the pulse is weak, there may be vomiting and purging. This condition may follow surgical operations, it may follow severe injuries, it may be due merely to great emotional disturbance. Shock is commonly observed in witnesses of great calamities, who have themselves escaped without a physical injury of the minutest character. In shock, however, we have the concomitant circumstances to guide us in making our diagnosis. The emergency treatment consists in prompt stimulation.



There are two causes of unconsciousness still left: concussion of the brain and compression of the brain. The first is caused by a sudden jarring—it may be from a blow or from a fall. In concussion we are apt to have vomiting, the pupils are even, there are no symptoms of paralysis. Often, however, there is no way of making a distinction. Again, the concussion may be so great as to cause a rupture of a blood-vessel and give us compression from a blood-clot.

Another ambulance case that I saw in Brooklyn was that of a man who, while in a drunken brawl aboard an excursion boat one Sunday afternoon, was knocked into the hold, twenty feet below the deck. When we got him into the hospital we found no evidences of anything more than a concussion. No fracture could be distinguished on the surface of the skull and the patient presented none of the classic symptoms of a fracture of the base, such as hæmorrhage from the ears, nose or mouth. No signs of paralysis were apparent. The patient remained in bed and unconscious for something over forty-eight hours. On the third day he became conscious, and by Thursday was feeling so well that he insisted on sitting up, and asked if he might go home. Friday morning he appeared to be perfectly well; Friday afternoon he died very suddenly. On autopsy we found no fracture, but we did find on the surface of one hemisphere the largest blood-clot I have ever seen in the human brain. The clot had made room for itself and was beneath the dura mater. Was this rupture of the artery caused at the time of the fall, or did it occur just before death? From the size of the clot it would seem as though it had been forming for some time, yet we had no symptoms.

Compression may be caused by a blood-clot from an artery ruptured by traumatism, or it may be due to a depressed fracture of the skull without a rupture. A compression will cause similar symptoms, no matter what its cause. The treatment is radically different. For instance, in a hæmorrhage caused by disease we have compression. The patient may recover from the first attack, but as disease of the brain-substance or of the blood-vessels must have reached a considerable degree of deterioration, a subsequent hæmorrhage is almost certain to occur. In our present state of knowledge not much can be done towards curing the underlying condition. Our greatest hope

is in hygienic treatment. The patient, if he live through the acute stages, may be cured of the resulting paralysis, but to prevent a recurrence he will be obliged to pay much attention to diet and to the habits of living. Everything tending to physical or mental strain must be avoided.

In hæmorrhage due to traumatism the patient may recover permanently, if the clot can be gotten rid of. *Arnica* is one of our chief remedies in this condition, rupture of the blood-vessels due to traumatism being one of its characteristics. *Hamelis* is another. For the resulting paralysis, *causticum* and electricity seem to be of most value. I have seen good results from *plumbum* and *arsenic*.

Where we have symptoms produced by an actual pressure of the bone, the indication is removal. One case I saw, a small boy of twelve, was so badly injured that his case was considered hopeless at first. After seven or eight hours, as he still showed signs of life, trephining was performed. The result was immediate; he recovered consciousness, and all of his faculties returned in full vigor. He became so mischievous that a special nurse had to be put in charge of him. In a week or ten days he left the hospital (Brooklyn) as well as ever, excepting for the hole in his skull.

The classical symptoms of a fracture at the base of the skull are hæmorrhage from the ears, nose, and mouth. I have seen cases of fracture at the base where these hæmorrhages did not take place, cases that were diagnosed only on the autopsy table.

The diagnostician does not want to be led astray by the sight of blood until he knows its origin. One ambulance patient of mine was found on the street in an unconscious condition late at night. The police supposed that the man was either knocked down or that he stumbled and fell, and so stunned himself. When the patient was landed in the station-house blood was found on his face, in his ears, and in his nostrils. A diagnosis of fractured skull was made, and a hurry-call sent for the ambulance. I found the man laid out in state on the floor, with several bluecoats on watch. I washed the face to see what my patient looked like. I found on the prominent part of the chin a superficial cut about an inch long, that looked as though the man had landed on his chin when he fell. In carrying him to the police station he had been placed on his back, and the blood

from his chin had found its way to the ears. The blood at the nose had probably been smeared by the hand of the patient. A few whiffs of *aqua ammonia* revived the man, his cut was sewn up, and I made a diagnosis of "plain drunk."

The ætiology of cerebral hæmorrhage has been incidentally referred to at various points in the discussion of the case under consideration. It is due, when not traumatic, to disease of the brain substance or of the circulatory system. Excepting in syphilis, or in abscess, we are not apt to have deterioration of the brain substance before middle life. When we do have disease of the brain from any cause, we will find some evidence of it in the previous history, either in disturbed mentality or in disturbed functions.

Disease of the blood-vessels is also a disease of middle life or old age. The older the individual the more apt we are to find it. The vessels, we know, lose their elasticity, and become brittle and more liable to rupture as life advances. Syphilis may cause an early degeneration, that is, early in the disease, no matter what the age of the patient. Bright's disease also causes a deterioration of the arteries. Goodno says chronic interstitial nephritis is the greatest offender in this respect. Heredity also appears to have some influence. The constant and long-continued use of liquor undoubtedly causes degenerative change in the arteries.

The history of the case that was the inspiration for this brief consideration of the various forms of coma follows:

The patient was a thick-set, heavily-built man of forty-one years. His occupation was unknown. The patient entered the Metropolitan Hospital on the afternoon of *Wednesday, February 16, 1898*. The family history was reported as good. (Some of the information detailed here was obtained from the patient himself, some of it was obtained from relatives and friends.) The patient had an attack of pneumonia several years ago. He is a heavy drinker. He has been feeling badly for several days, and has been trying to brace himself up by drinking more than usual. Last night, February 15, while sitting in a saloon, the patient suddenly fell from the chair to the floor. He says he struck his head as he fell; his friends say he did not. At any rate the head shows no evidence of contusion. From the statements of friends who were with him when he was stricken it was concluded that he probably fell



as the result of cerebral hæmorrhage. He was taken in a cab to several hospitals, but was admitted to none until he reached Bellevue. He was not treated there, but after an hour was sent to the Metropolitan.

On admission the patient was in a semi-stupor, from which he could be roused enough to answer questions. The speech was thick, and it was hard for him to talk at that time. The right arm and leg were found to be paralyzed—the left not. The right side of the face was also paralyzed, the mouth being drawn to the left. The tongue was also deflected to the left when protruded. The face was flushed, the skin warm and dry. Right eyelid paralyzed. Both feet and the right leg were cold. Efforts of the patient to move his right arm were fruitless; efforts to move the leg resulted only in a slight twitching of the muscles. There was a slight aortic systolic murmur found on auscultating the heart, and the left side was slightly enlarged. Respiration was stertorous. Testing for sensibility of the skin with cotton proved negative on the right side of the body and face, and positive on the left side. An analysis of the urine gave the specific gravity as 1018, reaction acid. Albumin was present. Some kidney and bladder epithelia were found, also granular and hyaline casts. The temperature on admission was 99°; at 6 p.m. it had risen to 100°. The temperatures throughout are for the axilla. During the evening of the 16th Cheyne-Stokes respiration was noted. The patient was put to bed with head raised. His stupor deepened rapidly. *Belladonna*, 1x, every two hours was prescribed.

*Thursday, February 17th.*—The nurse reported that the patient slept none last night. He complained of sharp, shooting pains from the back of the head to the left eye. This morning he felt better. Was able to move both arms and legs. Breathing more regular. Later he became comatose once more, with stertorous breathing. In the morning at 10 the axillary temperature was 97 $\frac{3}{5}$ °. In the afternoon it had risen to 102°. I saw the patient for the first time to-day. The face was flushed and hot. The man was in a stupor, but could be roused. His speech was so thick, however, that I was unable to understand what he said. The face was a little distorted, mouth drawn to the left. The breathing was very heavy. Muscles of the right arm and leg seemed to offer some resistance when I tried to move them; this made trying for the patella reflex very unsatisfactory.

I concluded that the case was one of slight hæmorrhage, possibly with some uræmia. The form of palsy pointed to hæmorrhage; so did the temperature; so did the gradual growing worse through the night. On the other hand, the slight improvement this noon and the condition of the kidneys, con-

firmed in a second urinalysis to-day, suggested uræmia. Then, too, the pulse was rapid—120 or more. Whatever the cause might be the symptoms called for *glonoin*, and this was at first given in the sixth decimal potency.

*Friday, February 18th.*—The patient was comatose all of last night. *Calomel* was given to move the bowels. Late this afternoon, while I was in the ward, the patient developed convulsions. Dr. Wallis, the house-physician, took charge and gave *digitalis* tincture, seven drops, hypodermically, as the patient seemed to be losing his grip. Ice was applied to the head and neck, and heat temporarily to the rest of the body. At 5 p.m. the axillary temperature was 105°. *Glonoin*, third decimal, was now given in drop doses every hour.

The convulsions were like those found in uræmia. The hands were clinched, the body rigid, the eyes staring and rolling. Both sides were equally affected. In apoplexy I have frequently seen convulsions of the paralyzed side alone.

*Saturday, February 19th.*—The patient had a number of slight convulsions, beginning at 2 a.m. After each the temperature was at 102° or a little higher, the pulse ranged from 130 to 140, the respiration 30 to 35. After 3.30 a.m. patient rested quietly for a while. Through the day there were a number of convulsions. The face was flushed each time and respiration nearly ceased. The patient perspired more or less freely. The patient was nourished with liquid food by the mouth and swallowed readily. In uræmia, patients usually swallow without difficulty, whereas in the paralysis of cerebral hæmorrhage the patient is apt to swallow with difficulty on account of the one-sided palsy. At 5 p.m. the pulse was 180. As the case presented some variations from a true apoplexy, and as the uræmic symptoms and the albuminous urine were present, I decided to try *Goodno's cuprum arsenicum*, third decimal. This was ordered in alternation with the *glonoin*.

*Sunday, February 20th.*—The patient began to swallow with difficulty. He was comatose all day. At 1 p.m. he tugged at the bedclothes and groaned when turned on his side. The pupils were tested with a lighted candle. The right pupil contracted slightly, the left more readily. I did not visit the hospital to-day, so the *glonoin* and *cuprum arsenicum* were continued.

*Monday, February 21st.*—Saturday and Sunday the temperature varied from 101° to 103°. This morning his sister visited him, and I was told that the patient seemed to know her. In the morning he turned to the light, and he moved when cold applications were made. When I saw him in the afternoon he seemed decidedly better than on Saturday. The pulse was 100, the breathing more natural. As he seemed so much bet-

ter I ordered the medicines changed to *arnica* in place of *glo-noin*, the *cuprum* to be continued.

The patient died at 10 P.M.

After carefully reviewing the case I have concluded that it was one of cerebral hæmorrhage. The patient was one of bad habits; he had used alcoholics for years, and his kidneys were degenerated. This resulted in weakened blood-vessels and he had the rupture. We were unable to get permission to make an autopsy. The temperature went up, dropped, rose again, and remained high to the end. The pulse was constantly rapid. The convulsions came on late. Had the patient lived he probably would have had aphasia, as it was difficult for him to enunciate when he was in his stupor.

Whether the fall he reported came before or after the hæmorrhage is a question. He may have been drunk and, in consequence, may have tumbled from his chair. On account of the condition of the arteries, that slight shock may have ruptured them. We know that apoplexy does not occur in healthy people. We also know that slight shocks may cause a rupture of diseased blood-vessels. There was no history, neither was there any evidence of syphilis.

I trust this brief consideration of various forms of coma, using as a text a case that none of you have seen, may be of some service to you in the days to come.

---

RATIONAL ETHERIZATION.—Dr. W. B. Brouner summarizes, as a deduction from his experience the following:

1. That etherization should be entrusted only to experienced hands.
2. That a special cone is not necessary for successful etherization. The simpler and less complicated the apparatus the better.
3. That the so-called force method of etherization is unnecessary, cruel, and oftentimes injurious.
4. That vastly better results are obtained by a gradual, quiet administration.
5. That the amount of ether employed should be minimized, preferably given drop by drop after anæsthesia has been fully established.
6. That the evil sequelæ are directly proportionate to the amount of ether employed, and indirectly proportionate to the duration of anæsthesia.
7. That the so-called baneful after-effects on the bronchus, stomach and kidney are largely over estimated, and in a large degree controllable.
8. That women require a smaller amount of ether, though a longer time to produce anæsthesia, than men.
9. That alcoholic subjects require a longer time and a greater amount of ether to produce anæsthesia and to maintain it.—*Medical Record*.



## EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

THE MEETINGS OF THE PENNSYLVANIA AND NEW YORK  
STATE SOCIETIES.

TUESDAY, Wednesday and Thursday, September 27, 28 and 29, 1898, has been selected as the time for the next session of the Homœopathic Medical Society of the State of Pennsylvania. The meeting to be held in the city of Pittsburg. This was done so as not to conflict with the Forty-Seventh Semi-Annual Meeting of the Homœopathic Medical Society of the State of New York to be held at Syracuse, Thursday and Friday, September 22 and 23, 1898, as many members of these Societies want to attend both meetings.

Most of the time of both Societies will be given to scientific work, and both Presidents, Keim and Norton, and the indefatigable Secretaries, Gramm and Moffat, have arranged excellent programs.

In both States important legislative matters demand an unusually large attendance. Especially is this so in Pennsylvania.

The time has arrived for renewed and increased effort to have the State of Pennsylvania make proper provision for the care of the insane for whom homœopathic treatment is desired.

Representing, as we do, the medical preference of a large class of taxpayers, we have the right to make such a demand, and when we can back the request by results in treatment of the insane in asylums far surpassing those of the allopathic school, our duty compels us to urge insistently our claim for recognition. The members of the Legislature will make no effort to correct this evil unless their attention is personally called to the situation by those directly interested, and it now becomes the duty of each member of the State Society, and of every homœopathic physician in the State, to make an individual and united systematic appeal to the members of the Legislature for the establishment of an insane asylum, to be under the sole medical care of physicians of the homœopathic school.

The State should not shower an abundance of care and provision upon one class of her citizens, as she has done at Norris-town, Harrisburg, Danville, Warren, Dixmont and Wernersville, and at the same time neglect and ignore her duty to those of another class who are now compelled to contribute nearly a third of the taxes supporting these institutions without representation, thus denying the physicians of our school their rights, and our patients the privilege of the treatment of their selection. The members of the Legislature are honest, fair-minded men, and, as a rule, are free from medical prejudice. They willingly recognize the claims of all classes of citizens, and when they comprehend that previous legislation has created and established in power a State medicine, they will correct the evil and extend equal protection and exact justice to all and special privileges to none. It is time to call a halt on the old-school monopoly of State medical appointments, and to ask for an equitable distribution of public patronage by the establishment of a well-equipped State hospital for the insane, to be devoted to the use of those desiring homœopathic treatment.

The Legislative Committee of the Society should give special attention to this important matter, and again lay before the Board of Charities a request for a homœopathic State hospital for the insane, and the members of the Society should assure the committee of their individual and united support and hearty co-operation in whatever steps they may find necessary to take for the purpose of obtaining the grant of such an institution. Only by united effort can success be obtained.

---

#### MILITARY HYGIENE.

WHILE the lamentable condition of hygienic affairs, medical and surgical, at Santiago, and on board the *Seneca*, have in a measure been explained by the Surgeon-General, and the responsibility shifted from his Department to the harbor there and to the "inexperienced civilian contract-surgeons," there remains one fact for which we have yet to hear any plausible excuse. We refer to the selection of unsuitable camping-grounds for the rendezvous of the troops during the long and

weary wait for a call to the front. In at least three instances grounds have been selected with a total disregard of the fundamental principles of military hygiene, in reference to water and drainage. The water proved, in quantity, entirely inadequate even for drinking purposes, not to speak of washing or bathing, while its quality was open to serious suspicion. To the character of the drainage facilities let the prevalence of illness testify.

We call typhoid fever a preventable disease in civil life, where there are so many circumstances and conditions not capable of direct control by the health officers; what can we say of the great prevalence of the disease in camps where the original location and the sanitation are subject to the disciplinary control of military life?

Our country is surely large enough to afford ample room for choice, and even here in the East there are areas extended enough, possessing all the requisites of ideal camping-grounds, so that the selection of such as have been referred to can only be explained, not excused, on the ground of ignorance, want of care, or interested motives.

In active service the camping-place is usually a matter of necessity and not of choice, but in the location of a mustering-in camp, in peaceful territory, such mistakes as have been made are inexcusable. Where the responsibility rests we do not know, but we hope that whatever rendered such things possible may be discovered, and meet with the public condemnation it so richly deserves, be it political influence, personal ambition or red-tapeism.

To every one who has followed the course of events during the prosecution of hostilities, and has read of the movements and counter-movements, the orders and the countermanding of orders, the "goings to start" and the not startings, etc., it must have become evident that, in spite of the praise we undoubtedly deserve for doing what we have done in the short time which has elapsed since the declaration of war, it is fortunate that we had an enemy such as Spain to deal with. The want of concentration of energy and of personal responsibility has seemed to us painfully evident. We should have thought that the lessons of the Civil War would not have been unlearned so soon.



Were we to wish to call attention to instances, within our own personal knowledge, of fever patients in Camp Alger whose pillows had not been turned for a week, they being too weak to do it for themselves, and to other instances of gross neglect, we would not know if we should ask the Surgeon-General whether he did not *now* need more nurses, or the Red Cross Society whether they did not need better ones.

The tardy abandonment of the unsavory Camp Alger will not bring back to life those who have died there, nor restore to health those who have been permanently invalidated by its imperfections, nor will it, we hope, prevent investigation to fix the responsibility for its condition.

In the Army Medical School, the establishment of which, in Washington, was authorized by the Secretary of War in 1893, we see that one of the five professors, selected from among the senior medical officers of the army, teaches Military Hygiene.

Good : such instruction seems sadly needed.

---

#### THE X-RAYS IN WAR.

AMONG the wonderful achievements of the X-rays there is none more beneficent than its banishment of the deadly probe from the treatment of gunshot wounds, as illustrated in the present war.

Though shorn of some of its terrors by the use of antiseptics, the probe is a thing of the past. Its use on the battle-field is forbidden, and in the hospital it is rendered unnecessary by the employment of the X-rays.

This renders possible, also, what seems to us an ideal treatment of many injuries received in battle, viz., the immediate application of an antiseptic occlusive dressing, which need not be removed unless demanded by later symptoms. Nature is given a chance, and meddlesome surgery will have fewer victims, and the wounded more limbs to carry home with them. Had the same principle been in vogue during our last war, our pension indebtedness would not be so large.

It is the common feeling among the laity that the oftener a wound is dressed the better for the patient; but modern sur-

gery does not countenance such an idea, and, after rendering a wound aseptic, is content to await developments. During and after a battle, apart from the acknowledged good results following this line of apparent inaction, the economy of time and labor which can be devoted to cases imperatively demanding other treatment is no small consideration.

The beautiful law of compensation is again illustrated in this, that while the instruments of warfare are constantly sought to be made more and more deadly and destructive, the use of antiseptics and of the X-rays becomes known in order to counterbalance their effects.

---

#### KEEP COOL.

THE present season offers exceptionally favorable opportunities for observing the effects of humidity combined with low barometric pressure upon the health and disposition. Records show that the greatest number of suicides is coincident with conditions of low pressure and high humidity,—and we don't wonder at it. With low barometric pressure the expanded air, deficient in oxygen and filled with watery vapor, will tend to deficient oxygenation of the blood, and consequent less vigorous performance of all the functions, a general lowering of the tone of both body and mind. Hence it is peculiarly our duty at such a time to avoid any serious drafts upon our energies, physical, mental or emotional. With such weather-conditions as have prevailed pretty generally for some time past, anything like anger or discussion is nearly equivalent to suicide, and bodily exercise should be restricted to that which is just necessary to the fulfilment of the most pressing duties.

*Festina lente*—Make haste slowly—should now, more than ever, be our precept and practice. Keep cool and quiet and you will be happy.

This advice should be particularly impressed upon those who are taking their vacations. We all know how soon after their return they are obliged to consult us in order to be repaired after their "summer vacation." The kind of rest they too often take is the hardest kind of work, and they must recuper-

ate from it at their usual occupations after their return. We will never learn to live rightly until we master the conception of the unity of all energy; until we feel that true ennui is as wearing as true work, that emotions as well as motions are accompanied by physical waste, and that this waste must be made up by physical means. If we can preserve the just equilibrium between eating and drinking, and thinking and feeling, and bodily activity, then shall our days be long in the land.

---

**TREATMENT OF SUPPURATIVE OTITIS MEDIA.**—In discussing suppuration of the middle ear Gradle remarked that the gauze drainage treatment was the speediest known in acute inflammation.

Any treatment which does not remove the odor from the discharge will never lead to a cure of chronic suppurative otitis media, and, conversely, wherever the odor has been removed the tendency to recovery can be at once observed.

A small number of cases may not entirely heal under the treatment which removes the odor, but this is a rare exception. He begins by a free use of the syringe.

“Thorough syringing alone cures many cases. I can say this on the basis of some cures accomplished by syringing, followed by the experimental use of various powders, like iodoform, which I since learned to be absolutely inert.

“All uncomplicated cases will heal under the use of boric acid lightly insufflated after thorough cleansing. This checks bacterial activity on the surface of the tissues.

“Insufflations through the Eustachian tube I formerly used as a routine measure, but I have failed to see the least delay from its omission. Irrigation through the Eustachian canal has not proved of use in my hands.”

He employs a small silver tube, closed at the end, with a lateral eye, attached to a ten-centimeter piston syringe, to irrigate the tympanic cavity. He uses a solution of salicylic acid in alcohol and ether (proportions not given), and follows this with carbolated glycerin, one to ten. Gradle agrees with advanced otologists generally respecting operative measures when they are required.

In some cases of a profuse, tenacious, muco-purulent discharge, which probably came from the mastoid antrum, he secured good results from a 20 per cent. solution of tannin and glycerin, retained in the ear for hours. Robert Telley prefers the method of syringing, in these cases, to the dry treatment. He uses a solution of carbonate of sodium (strength not given). Both gentlemen lay stress on the importance of naso-pharyngeal therapeutics in conjunction with ear treatment.

Dr. Wheelock syringes most cases with the dioxide of hydrogen. He has recently substituted a 0.5 per cent. solution of formalin for the  $H_2O_2$ , with satisfactory results.—*Jour. Am. Med. Ass'n.*, January 1, 1898.



## GLEANINGS.

---

**THE DIAGNOSTIC VALUE OF HEART-MURMURS IN CHILDHOOD.**—Dr. Soltmann recently read a paper on this subject before the Sixty-Ninth Congress of German Naturalists and Physicians, at Brunswick, Germany. The heart in childhood is less affected by diseases than in adult life. Anæmic murmurs are very rare in the first four years (Hochsinger) and rare up to the eighth year. This is due to the low pressure in the ventricles and the large area of the vessel-openings while at puberty, when the heart has reached its greatest development and the vessels are more constricted in their openings. This explains the frequency of anæmic murmurs in puberty. The murmurs of the first years of life are often due to compression, glandular swellings or thoracic deformities. In older children with true anæmia the murmur is heard most intensely at the pulmonary valve, and it is only systolic, without accentuation of the second sound; the heart-beat is found internal to the mammary line without heaving, and the pulse is not vibrating. Cardio-pulmonary murmurs are differentiated from anæmic by being accentuated by and synchronous with the first action, intermittent and accentuated by forced inspiration, and ceasing on suspending respiration.

In mitral insufficiency the murmur is always systolic and associated with heaving of the apex-beat. This symptom may be the only sign of endocarditis as the usual signs of adults, and especially increase of the heart's area may be absent. In children with lowered nutrition he has been able to detect heart-murmurs dependent on a degeneration of the myocardium and a relative insufficiency from dilatation.—*La Settimana Medica*, No. 22, 1898.—I saw some time ago a case of Basedow's disease in a girl of 9 years, who presented an anæmic murmur at all four valvular orifices.

**THE CLINICAL FORMS OF PULMONARY TUBERCULOSIS.**—Dr. Vergely divides the varieties into acute, subacute, and chronic. The acute may be subdivided into generalized, abdominal, and thoracic.

*Acute Generalized Form.*—Any serous membrane or any organ may be attacked, giving rise to the most varied symptomatology; though affecting preferably the lungs, general infection predominates, with bacillæmia.

*Acute Abdominal Form.*—Assuming a typhoid fever type or an infection of intestinal origin. Widal's reaction is a precious sign, though in typhoid it may be delayed, or the two diseases may be associated (Meunier and Guinon, Charrin).

*Acute Thoracic Form.*—It may be suffocating, bronchitic, broncho-pneumonic, pleural, or caseous. In the suffocating one may be deceived, thinking a hay fever or an attack of common asthma present. The evolution, the persistence, the intensity of the symptoms are differentially important. The bron-

chitic and bronchopneumonic types correspond to the catarrhal forms of Leudet and Empis. The symptomatology of the pleural form is varied; either insidious and mild, or in intensity, acuteness of pain and symptoms recalling a rheumatic pleurisy. ("I confess that the more carefully I have studied the question, the larger does the proportion appear to be of primary pleurisies of tuberculous origin."—Osler, *Practice of Medicine*, p. 559.) The caseous variety constitutes a process of intra-alveolar tubercular evolution. The special virulence of the bacillus brings about the violence of the symptoms and the rapidity of the course. Subacute tuberculosis or galloping consumption is a shortened chronic tuberculosis; consumption of the organism predominates. Bacterial association often occurs here.

Chronic pulmonary tuberculosis comprises five forms: The common form, the larvated or masked form, the latent form, the secondary and the associated forms.

*The Common Form.*—Dyspepsia and anæmia often signalize its beginning; herpes zoster, according to some authors, is a precious diagnostic sign of warning, and in the urine there is an increase of phosphates and chlorides or albuminuria (Teissier, "l'albuminurie pré-tuberculeuse"). This variety may be arrested in the first stage; but if progressing cavities form and the patient loses in flesh, and other symptoms set in, complications may modify its duration and course.

*Larvated Form.*—One should remember that it may be masked under chlorosis or pseudo-chlorosis, a dyspepsia, a bronchitis, a laryngeal catarrh, certain febrile complexes, simulating a quotidian intermittent, certain affections of the lymph glands, certain articulate affections or those of the genito-urinary tracts. (Maragliano, of Genoa, a few years ago called attention to these forms, and, above all, the dystrophic and anæmic varieties. He also warned against recurrent attacks of *seeming* typhoid fever.)

*Latent Form.*—To be distinguished from the larvated as deposition of tubercles may occur without special signs, both in benign and severe forms.

*Secondary Forms.*—Pulmonary tuberculosis may follow other localizations, as lupus erythematosus, where the course of the lung disease is usually rapid, while in lupus exulcerans it is very slow. Diabetes and syphilis have an aggravating influence on tuberculosis; influenza and pregnancy (Grisolle) also assist it onwards.

*Associated Forms.*—The importance of associated micro-organisms has been exaggerated. Schabad only recognizes the streptococcus as important. Tuberculosis may follow aspergillosis; the tubercular bacilli and actinomyces may be present together. He finishes by directing attention to tuberculosis in infants and old people. In the former it may occur under another disease-type, as typhoid fever, while in the latter, heredity, misery and alcoholism are the predisposing causes. The virulence of the bacillus is modified by its soil and the mode of entrance.—*La Settimana Medica*, No. 17, 1897.

THE PAIN AND MENSTRUATION IN ECTOPIC PREGNANCY.—Dr. D. C. Hirst, from observation of twenty cases of extra-uterine pregnancy, says that this condition is characterized by three orders of symptoms: the pain, the irregular menstruation, with possible expulsion of a decidua, and the local signs of the trouble in the tube.

As to the pains, they are very acute, paroxysmal, and may set in at any

minute during the course of the case. They are frequently localized in the inguinal region; in other cases they are seated in the lower part of the abdomen and radiate towards the lower extremities or the epigastrium. In certain cases these symptoms may be so intense as to occasion syncope associated with nausea, vomiting and symptoms of shock, without there necessarily being a rupture of the sac.

As to the menstruation, it is characteristically irregular; out of the twenty-two cases only six were wholly regular, in four they were only retarded from ten to twelve days, but in the majority there was a continuous bloody oozing preceded or followed by expulsion of a decidua.—*La Semaine Medicale*, No. 37, 1898.

In one case that I have observed the pain was intense and associated with pronounced shock, no nausea nor vomiting, but with a feeling as if she were dying—"a far-away sensation." The pains were atrocious and paroxysmal, of several hours' duration. A very text-book-like decidua was cast off. The uterus was pushed over to one side of the pelvis, and a mass was palpable alongside of it. The patient recovered without operation in the course of two or three months. There was a prolonged bloody dribbling from the uterus. In the May number of the *HAHNEMANNIAN MONTHLY*, 1898, I abstracted an interesting case of an unmarried servant girl, who suddenly was seized with spasms, but in a short time her case developed as an extra-uterine pregnancy. There was albumin in the urine. The spasms ceased; an abscess formed, pointing both in the vagina and near the umbilicus, whence foetal bones were discharged. She finally recovered. Who of us, if suddenly called in to such a combination of circumstances, would have unravelled this tangled skein? Verily, the trials of a "saw-bones" are many!

A "FROG-GIRL," AN "ANGLE-WORM BOY," AND A FEW OTHER CASES OF HYSTERIC SIMULATION.—In the Danish weekly medical journal, the *Hospitalstidende*, No. 24, 1898, there is published an interesting old document, where the local priest of a little Danish town calls attention (March 30, 1812) to the antics of a simple girl of fourteen years, who was in the habit of vomiting up live frogs as well as passing them through her bowels. She would exhibit them as having been vomited up or passed by her; but when watched or under the constant surveillance of the district physician, in his house, for five days the frogs ceased to appear, but as soon as she returned home the usual crop followed. On account of the interest of this case to medical science, the priest desired it investigated by the hospital authorities.

The following number of this same journal brought forth a notice of a similar case, which was published in the *Bibliothek for Læger*, 1840, 32te Bind, Side 315-320, where a boy of twelve years, with various hysterical symptoms, after treatment by vermifuges, passed a few ascarides. As the hysteric attacks continued, the treatment was kept up, and he soon began to pass both by the rectum and the mouth, by vomiting, a great number of ordinary "angle-worms." To the astonishment of the physicians and his friends, the boy was able, with the assistance of "white man with wings," of the name of "Peter," to predict how many worms there remained in his body and how they would pass. After three months' treatment, during which one hundred and ninety worms were passed, "Peter" prescribed a remedy, elder-bark tea, which alone was efficacious, and the worms never reappeared. Peter went his way, wishing the boy "Lykke i Verden," Good Luck.



In the first case I forgot to mention that the girl at times would be deaf, dumb, blind or raving. This latter state seemed to prevail. She never intentionally injured any one. Her actions and speech were childish.

I once treated a hysteric old maid who asserted that she had been passing bolts by the rectum. She had one bottled up in alcohol for inspection.

A practitioner in a neighboring town had a hysteric woman bring him a bottle of urine with a thick sediment in the bottom. He spent at least half a day in trying to detect what it might be. Under the microscope he recognized grains of starch, and with a few drops of tincture of iodine he obtained the characteristic blue reaction.—*Die Wirklichkeit die wir erleben uebertrifft die extravaganteren Wanderungen der Phantasie.*

**A NEW DIAGNOSTIC SIGN OF MEASLES.**—Dr. Henry Koplik, of New York, for a year and a half has noticed a symptom of measles which up to now has not been described. In the prodromal stage, besides the well-known blotches on the hard and soft palate, there are more or less numerous red spots on the chin and the mucous membrane of the lips of the size of a lentil, with a bluish-white centre. They cannot be confounded with anything else. They set in either before or with the first signs of the catarrh, and remain there several days. As soon as the regular eruption has broken out they, as a rule, cannot be seen.—*Medical Record*, p. 505, 1898.

Dr. Slawyk, of Berlin, has observed this characteristic sign among the children of the Pædiatric Clinic of the Charité of Berlin, and fully confirms what Koplik claims. With the aid of this sign he has been able to isolate children who later developed the pathognomonic exanthem of measles. He has never observed these spots in any other exanthem, and especially in rubella.—*Deutsche Medicinische Wochenschrift*, 1898, p. 269.

Abu Beer Mohammed Ibn Zacariyá Ar-Razi, in his work, *A Treatise on the Smallpox and the Measles* (900 B.C.), in chapter third, On the Symptoms which Indicate the Approaching Eruption of the Smallpox and Measles, among other signs, speaks of an *intense redness of the gums*.

**CASES OF THROMBOSIS AND EMBOLISM OF THE LARGE BLOOD-VESSELS OF THE ABDOMEN.**—Prof. Koester records a series of interesting cases which it might be well to present.

1. A man of thirty-one years suddenly presented the signs of an acute obstruction of the bowels with peritonitis. The autopsy revealed a thrombosis of the inferior vena cava, with incipient gangrene of a great part of the descending colon and of the whole curvature of the ileum. A few years before he had enterocolitis.

2. A woman of forty years a few months before had typhoid fever with following signs of intestinal stenosis. A laparotomy showed the lower portion of the ileum bound down by bands of omentum, fixing it to the other coils of intestine and the mesentery. They being freed, the patient did well for a few days. Two months after, signs of an enterocolitis appeared suddenly, violent pains and vomiting set in, with collapse. At the necropsy gangrene of the small intestine was found, extending from the junction of the duodenum and ileum to within a few cms. of the ileo-cæcal valve. He thought a thrombosis of the superior mesenteric vein the cause. The vessels running from the large intestine were normal. The cause was obscure.

*Thrombosis of the Superior Mesenteric Vein.*—A man of fifty-seven and addicted to liquor, in a bad general condition, and dropsical from a probable cirrhosis of the liver, died in collapse. Necroscopically, besides a cirrhosis and carcinoma of the liver, there was a gangrene of the small intestine, sixty-five cms. long, beginning sixty cms. below the upper end of the jejunum. The principal trunk of the mesenteric vein was uninvolved, but the vein corresponding to the gangrenous portion was thrombotic. His heart was also fattily degenerated. The cause was to be sought in the difficult circulation. Such cases are rare. Diagnosis during life is not always possible.

*Embolism of the Superior Mesenteric Artery.*—A woman of fifty-three years, who had had an apoplectic attack, was suddenly seized with pains in the abdomen and soon died. The necroscopy showed gangrene of the small intestine, commencing two inches above Bauhini's valve, and extending a metre and sixty cms. upwards. In a branch of the superior mesenteric artery an organized embolus, one cm. long, was discovered.

*Embolism of the Splenic Vein.*—A man of twenty-seven years, who showed signs of typhoid, after a rise of temperature, vomited and suffered extreme pains in the epigastrium. The spleen, which had remained normal, in two days assumed colossal proportions. The patient soon died. At the necroscopy, besides the lesions of typhoid, the spleen was seen to be enormously large and surrounded by omentum of a reddish and opaque color. The splenic vein in its whole extent was filled with a thrombus extending from the hilus, which adhered tenaciously to the walls of the vessel. He thinks a lesion of the intima, due to micro-organisms, the cause.—*La Settimana Medica*, No. 26, 1898.—Osler mentions three cases of blocking of the superior mesenteric artery, a serious and fatal condition which came under his observation. A man, aged forty, was suddenly seized with intense pain in the abdomen, became faint, fell to the ground and vomited. For a week he had persistent vomiting, diarrhoea, tympanites, and a great pain in the abdomen. The stools were thin, and at times blood-tinged. The autopsy showed an aneurism involving the aorta at the diaphragm. The superior mesenteric artery was blocked half an inch from its origin from the sac by a fibrinous clot from the aneurysmal sac.

SIGNIFICATION OF RUPTURE OF THE TUBE AND OF TUBAL ABORTION BY EVOLUTION, THE PROGNOSIS AND TREATMENT OF TUBAL PREGNANCY.—Prof. H. Fehling thinks tubal inflammation, especially of gonorrhœal origin, to be at the bottom of most tubal pregnancies. He regards tubal abortion, *i.e.*, expulsion through the abdominal end, as the ordinary termination of tubal pregnancy. Out of eighty-three cases observed at Basle, seventy-one were tubal abortions and seven ruptures. Three were operated while the sac was intact. Rupture is diagnosed by the sudden appearance of acute anæmia, the antecedents, the palpation of a soft mass behind or at the side of the uterus. It is a serious condition on account of the danger of death from internal hæmorrhage. With tubal abortion the symptoms develop less rapidly and the outlook is much better. Of ninety-one cases he has not lost one. If the hæmatocele increases in size, or if suppuration threaten, then do a laparotomy. Otherwise, rest is the chief treatment.—*La Semaine Médicale*, No. 37, 1898.

FRANK H. PRITCHARD, M.D.

**SURGICAL HINTS.**—In order to obtain union by first intention in an operative wound, it is generally important that all bleeding should be checked before the wound is closed. This does not mean, however, that every minor bleeding-point should be immediately seized and tied. This delays the operation, and is unnecessary, since pressure and exposure will suffice for all very small vessels. An undue number even of absorbable ligatures, when left in a wound, cannot but act as foreign bodies even if only temporarily.

It is worth while to remember the valuable therapeutic and stimulant action of very hot water in the treatment of chancres, chancreoids and old ulcers, especially of the indolent variety. If the water be applied gradually hotter and hotter, a surprising degree of heat may be stood. A few such applications a day will clean up and promote a healthy action in indolent or septic ulcers.

Never use force in washing out a pus cavity. The sac may be broken through, causing a deeper infection than formerly existed; this has occurred in appendicitis and other cases. In abscess of the frontal sinus fluid injected with too much force has been known to make its way under the skull and produce fatal pressure symptoms.

*Discard the Old and Dirty Poultice, a Remnant of Sombre Ages.*—Absorbent cotton or gauze soaked in hot water and covered with protective is clean, will remain warm just as long, is more easily prepared, and more pleasant to the patient.

In any case of intestinal obstruction, if a mild laxative and repeated high enemata fail to relieve, it is bad practice to continue the administration of cathartics. They cause irritation and congestion of the intestine, thus helping to lower the vitality. Any obstruction which fails to respond promptly to high enemata and a mild laxative is a case for operation.

In cases of fracture non-union is frequently due to the presence of syphilis. It is well, as a matter of routine, to inquire as to the existence of this disease in any case of bone injury, since active anti-syphilitic treatment will greatly promote union and repair in any case in which the disease exists.

Immediate amputation of limbs that have suffered from an injury attended with considerable loss of blood should always be avoided when possible. Wrap up the limb in copious aseptic dressings and wait until the patient is somewhat recovered from his loss of blood. Saline infusion and copious saline enemata will serve a very useful purpose.

Always give a guarded prognosis in operating for cancer. Now and then we meet with tumors appearing to possess an extraordinarily active proliferative power, and in which nearly immediate recurrence takes place in spite of the most thorough operative procedures.

After operations upon the face and mouth in children, or in any condition in which it is desirable to prevent the child from carrying its hands to its face, extend the arms and keep them extended by a few turns of a plaster-of-Paris bandage around the elbow-joint.

In children suffering from hernia a very common symptom of strangulation consists in retention of urine; such retention occurring without known cause in children should always lead to the suspicion that a strangulated hernia exists, and it should be sought for.

In skin suture use only as many stitches as are necessary to secure perfect approximation; multiplicity of sutures leads to more visible scars, wastes



time, and rather interferes with repair than promotes it.—*International Journal of Surgery*.

**A NEW OPERATION FOR BALANIC HYPOSPADIAS.**—Instead of forming a new urethra, I dissect free and extend the existing one so as to make it do the service of a new canal. First a transverse incision is made across the lower surface of the glands, which embraces the hypospadiac opening. By pulling the lower wound margin downward, the urethra can be exposed and separated from its surrounding tissue without being injured. Then, after a longitudinal incision has been made alongside the median line of the groove, by dissecting the edges of the groove, two flaps are to be formed and cut off in order to give a freshened surface. Now the hypospadiac orifice of the urethra is drawn forward and sutured to the initial point of these freshened margins of the groove, and opposite to it another suture is introduced in the same manner. If, now, the posterior portion of the displaced urethra is slightly inverted in its longitudinal direction, the retracted margins of the integument are pulled together and united above the urethra. The shape of the wound, which at first was transverse, now becomes longitudinal, forming a support for the urethra, which is thus kept straight at the same time.

It is evident that the urine does not come into contact with the wound itself, as the internal surface of the urethra remains intact. The creation of a new channel not having been necessary, the insertion of a tube will be useless.—CARL BECK, M.D., reprint from the *New York Medical Journal*, January 29, 1898.

**THE SHOULDER.**—Dislocations involving the acromio-clavicular articulation present several features of striking interest.

1. They are comparatively rare, though not so much so as supposed.
2. Because of their infrequency, their masked position in fleshy subjects, the slight impediment in function present, and of the usual superficial examination, they are very often overlooked, after injury, until it is too late to secure permanent readjustment.
3. Even when they go untreated, the degree of deformity resulting is not very marked, and the recovery of a very large share of the function of the shoulder is the rule.
4. For evident anatomical reasons this is a type of luxation which surgical expedients are quite impotent to reduce and retain by any operative procedure.

Dislocations involving the scapulo-humeral articulation are most complex and intricate in character. . . . The usual rules laid down in text-books, or even in special treatises, are well enough for ordinary cases, but they are all fundamentally incomplete because (in all I have examined) the most cardinal of all signs is neither emphasized nor, in some instances, even mentioned. Lengthening of the arm, unevening of the circumference of the shoulder girdle (as lifting of the axis of motion) with marked depression of the sub-acromia may all exist, with the head of the bone still in position. Hence in all cases our first step should be to determine if the humeral head has been dislodged. In order to accomplish this it is necessary to first know where the structure is most accessible and superficial, and how it can be brought nearest to the surface. It is most superficial in the apex of the armpit. By bringing the arm directly upward on a plane with the

body, and at the same time slightly adducting and rotating it outward, the round humeral head may be felt in the costa between the long head of the triceps behind and the posterior border of the short head of the biceps and the coraco-brachialis. Here it is only covered by the tendon of the subscapularis, its capsule and the integument, when the nerves and blood-vessels are gently pushed aside.—THOMAS H. MANLEY, M.D., in *American Journal of Surgery and Gynecology*, June, 1898.

RESIDUAL GONORRHOEA IN WOMEN.—Dr. Valentine tells how some men contract gonorrhœa when the source of infection is obscure. He cites a number of cases and draws the following conclusions:

1. Like a man, a woman may have residual gonorrhœa, without any external manifestations.

2. A woman with residual gonorrhœa is more likely to infect a man with whom she cohabits during the hyperæmia immediately preceding or still remaining after menstruation.

3. The likelihood of infection is probably greater if the coitus produces an orgasm in the woman.

4. A sub-mucous intra-uterine habitat of gonococci can be reached only by thorough curettage.

5. No woman should be pronounced cured of a gonorrhœa until the scrapings from the cervix and uterine lining are proven to be free from gonococci.—*American Journal of Surgery and Gynecology*.

F. WALTER BRIERLY, M.D.

PUERPERAL SEPTICÆMIA TREATED BY HYPODERMIC INJECTIONS OF CREOSOTE.—Dr. Geo. F. Jenkins, Keokuk, Iowa, reports the following case:

"Mrs. T., aged thirty-eight and mother of ten children, a fleshy woman with a very pendulous abdomen. I found her lying in bed with a pulse of 120, and temperature 102 degrees. She was lying on her side, and the fundus of the uterus resting on her knees—all support from the abdominal muscles being removed, the uterus had dropped forward and downward. The pubes acted as a fulcrum, and all the ligaments stretched to such an extent that the os was lifted into the abdominal cavity and pointed upward and backward. The child being evidently dead, a fetid discharge from the vagina.

"She already had puerperal septicæmia, as evidenced by the quick pulse, elevated temperature and other symptoms. I immediately irrigated the vagina with a warm bichloride solution, placed her on her back, and with my hands under the fundus, lifted it upward and into the normal position and had it held there by the nurse, while I, after another antiseptic irrigation, proceeded to deliver, by manual dilation of the os and the subsequent application of the forceps. She was very soon delivered of a large boy, that had been carried over time, and had evidently been dead about ten days.

"The uterus was immediately irrigated with a hot bichloride solution, followed by sterilized hot water. She suffered from great pain, had a pulse of 140, temperature 103 degrees, with vomiting and great exhaustion. I gave her a small dose of morphia and atropine hypodermically, also a large dose of digitalin and strychnia, by the same method. These remedies were given by the nurse every three hours, alternately, during the night. When I saw her in the morning the abdomen was very tympanitic and tender, temperature 103½ degrees, and other symptoms greatly aggravated. I washed out the ute-

rus again with the antiseptic solution and sterilized water, and continued to do so night and morning.

"All the symptoms being very unfavorable, I concluded to try creosote hypodermically, in large doses. I went to the drug store and got the following prescription: Beechwood creosote, camphorated oil, aa ʒi.; Sig. Shake well and give twenty drops hypodermically, in the thigh, every four hours.

"This was given faithfully for several days, and seemed to lower temperature, control vomiting, relieve distention of abdomen, and stop fetor of the lochia.

"She made a rapid and complete recovery. Her last five children have been dead born, and from what I could learn, death in each case was caused by the abnormal position of the uterus during the later months of pregnancy. I have tried the hypodermic injections of large doses of creosote in one other very severe case of puerperal septicaemia since, with the same happy effect. Of course, I washed out the uterus and gave other orthodox treatment in both cases, but I believe that creosote was very largely instrumental in saving the lives of both patients, and without such treatment one of them certainly would have died."—*N. Y. Medical Times*, July, 1898.

**METRITIS WITH NERVOUS COMPLICATIONS.**—Dr. J. C. Kilgour, Harrison, Ohio, reports the following case: A married woman, aged 24 years, who had never been pregnant, had suffered severely with each menstrual flow. Examination revealed an eroded os, metritis and cervicitis, an extremely narrow cervical canal. She suffered severe pains, coming on in paroxysms every few minutes, drawing her body into that position seen in strychnia poisoning; the abdomen arched upward fully a foot from the bed, the hands tightly clenched, eyes rolled backward, jaws firmly set, lips drawn back, simulating that sardonic grin, the respiration suspended. In this condition she would remain for fully a minute, then fall back suddenly on the bed breathless, and perspiration pouring from every pore. Hypodermic injections of morphia, quarter grain at first, sufficed to keep her quiet for eighteen hours, but later lost its effect, and had to be used every six hours. Dilatation and curetting was performed, with the hope of benefiting her, but after the operation her paroxysms were worse than before. Calc. phos., 3d trituration, 2 gr. powders, every two hours, was then administered. The result was most successful. After the third dose the paroxysms were lighter, and in forty-eight hours had ceased. The next period came without pain, and was very profuse.—*Eclectic Medical Journal*, July, 1898.

W. D. CARTER, M.D.

**PUERPERAL ECLAMPSIA.**—(Qui.) Eclampsia is an auto-intoxication, and whether or not of bacterial origin it has three therapeutic indications:

1st.—Prevention of toxine formation.

2d.—Elimination of toxines.

3d.—Treatment of its manifestations.

As a prophylactic measure, every pregnant woman with albuminuria should be placed on absolute milk diet, 2½ to 3 litres daily. Daily movements of the bowels should be secured. In case of prodromal symptoms of eclampsia cathartics should be given, four to eight grams of chloral in twenty-four hours, and absolute rest in bed. If convulsions have occurred, he recommends chloral and chloroform at the moment of convulsions, and condemns the large doses



of morphine sometimes used in Germany. Toxemia is to be met by the generous use of milk and the subcutaneous injection of physiological salt solution, 300 to 400 cubic c.m. several times a day. It may be necessary to convey the milk directly to the stomach by a tube. Venesection is applicable only in cases of threatened œdema of the lungs or brain, and never more than 300 to 400 grammes at a time should be injected. Strong antiseptics, such as carbolic acids and corrosive sublimate, are absolutely contra-indicated in eclampsia.—*Ibid.*

**THE CÆSAREAN SECTION VERSUS FŒTAL MORTALITY.**—Reynolds is of the opinion that the maternal mortality has now become so low that its performance is justified in all cases in which a mechanical obstacle renders the delivery of an otherwise healthy woman by the usual obstetrical operations more than ordinarily difficult or dangerous; *i.e.*, there is no longer a question of the relative positions of the Cæsarean section and craniotomy on the living child in healthy women not exhausted by long labor. He considers the methods of estimating the size and consistency of the fœtal head very inaccurate which make pelvic measurement a matter of scientific interest rather than of practical importance, and that a pelvis having a conjugate of three and one-half inches may offer an obstacle merely prolonging labor, or so great as to render impossible the birth of a living child. In expert hands, if the fœtal heart is undisturbed and the mother not exhausted, Cæsarean section is to be recommended in preference to an exceptionally difficult forceps operation or version. In pelvis with a conjugate of less than three and one-quarter inches the Cæsarean section is the operation of election under favorable circumstances.

These opinions were considered rather too advanced by distinguished Philadelphia obstetricians before whom the paper was read.—*American Journal of Obstetrics*, June, 1898.

**IRRIGATION WITH SALT SOLUTION IN SURGICAL PRACTICE.**—Hunter Robb advocates the use of sterile salt solution in preference to any other fluid in washing wounds. It has no injurious effect on the tissue cells as other irrigating fluids have, and the stimulus of it in abdominal operations diminishes shock. It tends somewhat to prevent the clotting of blood from cut vessels, but he has not seen any suppuration follow its use.—*Ibid.*

**TREATMENT OF PUERPERAL SEPSIS.** (Mundé.)—The first indication is to remove all foreign substances from the endometrium, preferably with finger; otherwise, with a long, large, blunt curette, and irrigate with a mild solution of permanganate of potash, 10 per cent. solution of chloride of zinc, or peroxide of hydrogen diluted one-half. He does not think well of iodoform pencils after curetting. Packing the endometrium with iodoform or sterile gauze may be desirable to produce uterine contraction.

In very bad cases of septic endometritis do not use the curette, as it removes tissues which have already undergone inflammatory obliteration of their absorbent vessels, and which are no longer a source of septic infection. The curette simply lays open fresh channels for infection, as it is impossible to remove every microscopic vestige of the septic decidua. It is far better in these cases to apply to such an endometrium a 20–30 per cent. solution of chloride of zinc, pure tincture of iodine or iodized phenol, and to irrigate the loose debris away

with sterile water, and pack with iodoform gauze for forty-eight hours. When the uterine cavity is entirely empty and there is nothing to produce sepsis, even if a high temperature and pulse indicate sepsis, there is no use in giving intra-uterine irrigations.

The medical treatment is very unsatisfactory. The ice-bag, sponging with cold water or alcohol, or the ice-water coil, may be helpful. He has in three desperate cases seen recovery follow the injection of anti-streptococcal serum. —*American Journal of Obstetrics*, July, 1898.

**THE AFTER-TREATMENT OF PERITONEAL SECTION.**—Byford advocates the administration of a saline purgative the day before section, and two hours before the time set for operation two teaspoonfuls of the fluid extract of cascara.

As soon as the patient awakens from the anæsthetic, a drachm of sulphate of magnesia in an ounce of water or an equivalent dose of some mineral water, or an ounce and a half of the liquid citrate of magnesia is given every hour, and repeated immediately whenever vomited. About six hours after the operation is completed a stimulating enema is given, consisting usually of two ounces of glycerin and four of water, or from half to a drachm of inspissated oxgall in half a pint of water (without glycerin) is thrown into the upper rectum, and repeated every two or three hours until flatus passes freely between enemas. When this occurs the saline is also stopped, but not till then. It is not sufficient to merely start gas and fæces with the enema. The treatment must be continued until flatus passes freely between enemas, and if it ceases to pass occasionally afterwards another enema should be given. The patient is nearly always perfectly comfortable after flatus passes freely. If raw intestinal surfaces are left after a difficult operation he sometimes gives a high glycerin enema before the patient is taken from the operating-table. He has had a consecutive series of one hundred and five recoveries after peritoneal sections under the above treatment.—*Ibid.*

**THE SURGICAL TREATMENT OF IRREDUCIBLE RETROFLEXION OF THE PREGNANT UTERUS.** (Mann.)—The writer reports two interesting cases in which the abdomen was opened. All other means having failed, the hand was introduced behind the uterus to overcome atmospheric pressure and to raise up the fundus into the false pelvis. The abdomen was closed in the usual manner and the patients went to full term.—*Ibid.*

**ALCOHOL AS A DISINFECTING AGENT.** (Gœnner.)—The writer has made a careful bacteriological study of the subject and concludes that it is inferior to sublimate, and recommends the latter in preference. Thorough washing and rubbing of the hands in 96 per cent. alcohol showed them to be aseptic in 88.88 per cent. of the trials. Washing for ten minutes even did not insure sterilization.—*Centralblatt für Gynäkologie*, No. 18, 1898.

**THE TREATMENT OF ATONIC UTERINE HÆMORRHAGE.**—Arendt recommends in atonic hæmorrhage from laceration of the cervix seizing both lips of the cervix with Muzeux's forceps and strong traction downwards. The vessels are not only compressed, but the mechanical irritation stimulates uterine contraction if traction and relaxation are practised.—*Therapeutische Monatshäfte*, January, 1898.

GEORGE R. SOUTHWICK, M.D.

WHY THE PROPORTION OF BLIND IN THE COUNTRY IS GREATER THAN IN LARGE CITIES.—Dr. Lucien Howe, of Buffalo, says that in the twenty-five largest cities of the United States the proportion of blind is, with two exceptions, smaller than in the States in which these cities are situated; or, taking all the cities of over 50,000 inhabitants together, there are in them about 33 per cent. less blind than the average for the entire country. In examining the different factors in the production of blindness, whether congenital or acquired, or, if of the latter class, whether due to traumatism, general disease, or to local diseases, these factors are all practically the same, or are made equal, in city and country, with one exception, namely, ophthalmia of infancy. Extended inquiry concerning the habitual practice of physicians in country almshouses, in hospitals and elsewhere, in the State of New York, indicates that more attention is given to guarding against ophthalmia of infancy in the cities than in the country. This tendency to neglect, or habitual disuse of, such prophylaxis tends to make a radical difference in the distribution of the blind, estimated at possibly 14 to 1.

It is at least the most apparent cause of this difference, and probably accounts for the greater part of it.

It follows, from this apparently warrantable conclusion, that if as great care were taken in general throughout the country as is given on the average in the cities to such prophylaxis, the number of blind in the United States would be decreased in a single generation by some few thousands. While it is neither advisable nor possible to force by legislation any one method of preventive treatment upon physicians in private practice, it is the right and duty of the State to provide for children born in almshouses the best treatment thus far known, and to require for them the use of solutions of silver nitrate, or of some other prophylaxis that may in the future prove to be equally efficacious.—*Proceedings American Ophthalmological Society*, July 20 and 21, 1898.

NEW TREATMENT OF ULCER AND OTHER INFECTIOUS DISEASES OF THE EYE BY CASSAREEP.—Dr. S. D. Risley said that this preparation is made from the juice of the black cassava, and is used in a 10 per cent. ointment.

It is applied freely between the lids, and the eye is subjected to massage to distribute it, and in the corneal cases a protecting bandage is applied. It causes no irritation and rapidly brings about improvement.

Dr. John Green stated that he had seen the natives making cassava-bread, and that among them the juice has the reputation of being preservative of flesh.

Dr. Myles Standish said that he has been using the preparation since Dr. Chandler originally introduced it, and he thought that, in the case of corneal ulcers, if the ointment be used for some time after healing has occurred, the scar is less dense than if treated by other means.

Dr. Jack has used the preparation, but said that in some cases it has been rather irritating. Dr. Risley added that he had not noticed any difference in the degree of opacity, as compared with the result of other methods of treatment, but he believed that that would depend rather upon the amount of tissue destroyed.—*Proceedings American Ophthal. Society*.

AURUM TRIPHYLLUM has a marked effect upon the larynx. It has a hoarseness which is characterized by a lack of control of the voice. The patient attempts to speak in a certain tone, when it goes off in a *squeal*.

WILLIAM SPENCER, M.D.



## MONTHLY RETROSPECT

### OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

---

ENURESIS NOCTURNA.—Dr. Boffenmeyer, in cases of wetting the bed, where the disease has been due to worms, with rubbing of the nose and emission of a clear urine, which, on standing, becomes milky, has found *cina* 1x, three or four drops, several times a day, in a teaspoonful of water, a sovereign remedy.

*Viburnum prunifolium*, fluid extract, is also a useful remedy, one giving as many drops as the child is old, three times a day.

Children should be taught to make their water at certain hours both day and night. The supper should be eaten at least one hour before going to bed, with avoidance of too fluid and irritating foods. Let the children lie upon their sides, and never on a feather bed.—*Homœopathische Monatsblätter*, No. 7, 1898.

A FEW HINTS FOR THE TREATMENT OF BRIGHT'S DISEASE.—Dr. Clifford Mitchell recommends *ferrum* and *strontium*, which have succeeded better in his hands than any other remedy. *Aurum mur. natron.* also has a favorable action in the polyuria of contracted kidney. Caffeine is the best drug for the uræmic headache. In desperate cases with dropsy, he administers these drugs in alternation.—*L'Art Medical*, No. 6, 1898.

RANDOM THERAPEUTIC HINTS.—Dr. Mackenzie cured a case of lichen of several months' duration with *arsen. iodatum*.

Dr. Robertson has found *ipecac* 3x superior to all other drugs in seasickness.

Dr. M. Deschere has aborted a felon with *natr. sulphur.* in two days.

Dr. Cash reports two cases of advanced *phthisis pulmonalis* where *stannum* 3x brought about a notable amelioration.

Dr. C. T. Haete employs *kali phosphor.* in uterine inertia.

Dr. Lutan, being called to a primipara, observing the labor to progress almost without pain, learned that she had drunk an infusion of blue cohosh roots—*caulophyllum*—twice a day for four or five months.—*L'Art Medical*, No. 6, 1898.

A MEDICO-BOTANICAL STUDY OF *VISCUM ALBUM*.—Dr. Staeger, from a study of the olden literature, recommends *viscum*—mistletoe—in epilepsy, convulsions and eclamptic states, in hæmorrhages of all kinds, in metrorrhagia, and in labor to expel the fœtus or the secundines.—*Journal Belge D'Homœopathie*, No. 2, Vol. V.

A CASE OF THROMBOSIS OF THE INFERIOR VENA CAVA.—Prof. Robert Saundby, of London, recently observed a woman of forty-seven years who was suffering from extreme dyspnoea, was very cyanotic, presented oedema and many varicose veins of both lower extremities. The abdominal and thoracic veins, which were visible exteriorly, were decidedly dilated and serpentine, especially of the left side. The border of the liver extended two fingers' breadth below the ribs, the heart-sounds were irregular, and at the apex a slight systolic murmur was audible. Fluid was to be detected in both pleural cavities. The urine contained albumin as well as hyaline and granular casts. At the necropsy the lower vena cava was found wholly occluded from its termination up to the entrance of the hepatic veins; only at the lowermost end were loose coagula to be made out. The portion above was filled with a firm and compactly-organized tissue; the right renal vein was also occluded, the left only between the vena cava and the entrance of the vein of the ovary.—*Wiener Medizinische Presse*, No. 27, 1898.

Several years ago I saw, in Boston, a boy of about twelve years, who was under treatment for an eczema of the leg dependent upon varicose veins caused by an occlusion of the inferior vena cava. His legs and abdomen were covered with dilated and tortuous veins, which reached over the whole abdomen up to the thorax. They ranged in size from a mere venule to a vessel of the size of a goose-quill. This case was reported by Dr. Scudder, of the Harvard College Medical School, in the *Archives of Pediatrics*.

PERTUSSIN, A SACCHARATED EXTRACT OF THYME, IN WHOOPING-COUGH.—Prof. Ernst Fischer, of Strassburg, had the misfortune to have all five of his children, ranging in age from 10½ years to 10 months, to fall sick with measles, followed by whooping-cough. The course of the disease was the usual one, without complications. Tussol was first administered, but without effect; then pertussin, a much-advertised German whooping-cough remedy, and an extract of thyme in syrup, were given. The remedy was pleasant to take, and all the children willingly took it. The result was astonishing. In a few days the disease was changed into almost a simple bronchitis. The attacks became milder, the phlegm looser, the cyanosis and choking wholly disappeared. The children were given a change of air, and in a few months the disease had wholly disappeared. In acute and chronic bronchitis he also found it of great service in loosening the mucus. In old cases of emphysema he found it of great value in aiding expectoration. He heartily recommends it to surgeons for the bronchitis which follows anæsthesia in old subjects, with chronic bronchitis and emphysema. This preparation is made by mixing a fluid extract of thyme (German variety) with syrup so that it represents an infusion in the strength of 1 : 7.—*Deutsche Medicinische Wochenschrift*, No. 27, 1898.

The writer goes on to state that this drug was well known to the ancients for its loosening effects upon expectoration. Ibn El Baitar (1197-1248), a physician and naturalist of Malaga, in his renowned work, *Grosse Zusammenstellung ueber die Kraefte der Bekannten Einfachen Heil-und Nahrungsmittel*, aus dem Arabischen uebersetzt von J. v. Sontheimer, 2 Bd., Stuttgart, 1840-42, has collected all the ancient literature. Dioscorides Pedaninus Anazarbeus (60 years after Christ) says: "A decoction with honey, taken internally, is of service in difficult breathing which is only ameliorated by the upright posi-

tion, as well as in asthma. If given in an electuary, it augments expectoration. It also expels round worms." Thymol has been employed of late as an anti-parasiticide, especially by C. Bozzolo.

FRANK H. PRITCHARD, M.D.

**THALLIUM FOR BALDNESS.**—A paragraph in the *Chemist and Druggist* states that Dr. Huchard read a paper at the last meeting of the Paris Academy of Medicine on acetate of thallium, which was formerly advocated by Dr. Combemale, of Lille, as a medicament against profuse perspiration in certain cases of serious illness. It appears, however, that its useful influence is counterbalanced by the fact that it causes the hair to fall off with great rapidity. Dr. Huchard exhibited at the meeting several photographs of patients who had become quite bald in several days. He was consequently very emphatic against the use of the remedy.

Commenting upon this, the *Homœopathic World* (June 4, 1898), remarks that there is all the difference between the two schools in this note. To the allopath this is a "curious effect" merely, and serves to condemn the drug. To the homœopath it brings to light a new remedy for a troublesome affection, which is by no means too well provided for.

Thallium is a rare metal, whose atomic weight is 204.2, its symbol being Tl. It receives its name (*θαλλός*, a green shoot) from the green line it gives on the spectrum, through which it was discovered by Crookes in the residuum left from the distillation of selenium. Thallium has a bluish-white tint and the lustre of lead; it is so soft that it can be scratched by the fingernail. It belongs to the lead group of metals, but has peculiar reactions of its own. It is used in the manufacture of a glass of high refractive power.

**THE ANÆMIA OF LEAD-POISONING.**—The anæmia of saturnine poisoning is a striking feature of its symptomatology, and Blackley, of London, in the course of an article on the action of some of the principal hematics, suggests that there should be something of a future for lead in the treatment of pernicious anæmia. Malassez and Limbeck, in examining the blood of saturnine patients, have found the number of red corpuscles very much below the normal, the figures ranging from 3.7 down to 2.2 millions. Malassez also noticed in his cases the appearance of megalocytes. Hayem regards the change as being rather chlorotic in character, but in noticing the diminution in number of red cells, records their irregularity, both of size and shape, and observed that some were partially decolorized. The writer has been able to verify this quite recently in a case of lead-poisoning (colic and wrist-drop, with well-marked blue line on the gums); although the number of red corpuscles and hemoglobin percentage were little out of the ordinary, the poikilocytosis and variations in size were pronounced, and a few megalocytes were present.

Quite as striking from the hæmatologist's point of view are the profound changes in the gastric glands of an atrophic character, described by Kussmaul and Meyer, in the cases of chronic saturnism examined by them, a condition directly responsible for the anæmia, as Henry, Osler and Kinnikut have all directed attention to the common co existence of grave anæmia with profound changes in the gastric mucous membrane. In the somewhat rare disease known as *psilosis linguae*, or "Indian sprue," the essential lesion of which is an atrophic condition of the mucous membrane of the alimentary tract,



the blood condition is such that but for the history of the case one might easily mistake it for one of pernicious anæmia.—*Journal of the British Homœopathic Society*, July, 1898.

**THE HOMŒOPATHIC TREATMENT OF PNEUMONIA IN CHILDREN.**—Mr. F. A. Watkins, late Resident Medical Officer to the London Homœopathic Hospital, summarizes the symptoms, course, treatment and results in fourteen cases of broncho-pneumonia and three of croupous pneumonia in children under five years of age lately admitted to the London Hospital. Of the former all recovered, while of the three cases of croupous pneumonia two died, one being moribund on admission. Examination of the hospital records for the last five years shows that 49 children, up to the age of five years, were admitted for broncho-pneumonia, and of these only six died. Four of the fatal cases were admitted in a moribund condition, and two were complicated with croup. This mortality of twelve per cent. compares more than favorably with the statistics from allopathic sources.

The writer makes a few valuable observations regarding our remedies. Aconite is useful only during the early stage of the disease, and should be stopped as soon as there is evidence of consolidation. Antimonium tart. is our sheet-anchor, especially when there is much rattling of mucus; it should always be given in trituration, as the solution readily decomposes. Phosphorus is indicated when the lungs are in a drier state and there is much consolidation. Iodide of arsenic is of special value when the broncho-pneumonia is of influenzal origin, and is always invaluable when the temperature drops to normal, in order to promote resolution, and is especially useful when there is diarrhœa and other digestive disturbance.—*Journal of the British Homœopathic Society*, July, 1898.

**THE ACTION OF CAUSTICUM.**—Cowperthwaite, of Chicago, speaks with regret of the neglect into which causticum has fallen. He considers it a remedy of great power, and although its exact constituents are unknown, it is essentially a potash preparation, and possesses many distinctive qualities of the potash salts. It acts especially upon the motor nervous system, giving rise to paralytic conditions, more particularly of the face, larynx and bladder. It also has a remarkable action on the mucous membranes, especially those of the respiratory tract. It shows its power in disease in which there is great weakness: a genuine potash indication which we find running all through the potash salts. The causticum patient has, too, the timidity characteristic of potash—full of painful fancies in the evening, the child is afraid when alone in the dark, apprehensive. When closing the eyes frightful images appear. The patient is constantly sorrowful with weeping. The face is a correct mirror of his condition. It is sallow, sickly-looking and expressive of his melancholy. Memory is weak, he is giddy, with a sensation of weakness in the head. The sight is dim, as from a fog over the field of vision. But more important than all these systems is the paralysis of single nerves, as of the face, the tongue, lips, the eyelids, one arm or one leg, or the laryngeal muscles, the bladder, etc.

The writer has had remarkable results with causticum in the treatment of facial paralysis and in aphonia of parietic rather than of catarrhal origin. It is useful, also, in a great variety of other parietic conditions, whether accompanying deep-seated brain or spinal lesion or of rheumatic origin.—*Medical Era*, August, 1898.

F. MORTIMER LAWRENCE, M.D.

# THE HAHNEMANNIAN MONTHLY.

---

OCTOBER, 1898.

---

## A PLEA FOR EARLY OPERATION IN MAMMARY TUMORS.

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

Read before the Homœopathic Practitioners' Association of Reading, Pa., August 24, 1898.

IN June, 1895, I had the honor to present a paper to the Massachusetts Surgical and Gynæcological Society on the "Surgical Treatment and Prognosis of Carcinoma of the Breast."\* This formed a part of the general topic for discussion on mammary and uterine cancers, and was based on a study of 69 breast excisions. Since that time the number has been increased to 151, but the convictions there expressed, instead of being modified, have been decidedly emphasized.

With your permission, I will quote a few of these convictions:

- (1). "Every nodule in the breast should be incised—usually excised, and examined.
- (2). "Malignancy calls for the most radical operation, no matter how limited or movable the infection.
- (3). "Early operations hold out the only hope in this most gloomy of diseases. Late operations are only palliative and often detrimental.

---

\* *New England Medical Gazette*, July, 1895.

(4). "I am almost ready to believe that a breast containing an abscess is as well out as a pus-tube," etc.

I therefore beg leave to take a little of your time in making a plea for earlier and more frequent—nay, universal—operative interference in all mammary tumors, or, to speak my meaning more correctly, if not as technically, all nodules or "lumps" *in or about* the female breast.

In order to arrive at a better understanding of such an argument, it may be worth our while to review briefly the anatomy and histology of the normal breast, to sum up the principal morbid conditions met with in the gland, and to cite a few clinical cases to demonstrate the conclusions drawn. In these studies, as well as in other pathological work, I wish to express my obligation to Dr. P. Sharples Hall, our Professor of Pathology, who has made slide-mounts or bacteriological investigations of every specimen removed by me during the last three years; also to Professor R. B. Weaver—too well known, in spite of his modesty, to require any introduction—for dissections, specimen preparations and invaluable anatomical advice.

The mamma is a compound, racemose gland made up of lobes and lobules, tubules and acini, held together by connective-tissue containing the vessels, nerves and lymphatics, and enveloped by a fibro-fatty capsule. In the full-grown virgin breast we find chiefly fibrous tissue, coarse in structure, poorly supplied with cells and very like tendon; the lobules are small and ill-developed, situated deeply, while few of the ducts possess terminal acini. The lining epithelium is of the columnar variety, of a low grade, upon a structureless basement-membrane. With the commencement of pregnancy, new branches are sent off from the milk-ducts and corresponding acini are formed. At term, when the gland has reached its complete functional size and activity, the stroma has become soft and lax and contains a large number of fully-formed lobules. The latter, as in the nulliparous breast, are deeply seated, numbers of them being found in the surrounding fatty tissue, the capsule having become especially defective underneath. The same is true, to a less degree, of the anterior surface, where glandular tissue is found about the fibrous bands attaching the breast to the skin—the "suspensory ligaments of Cooper." With the



cessation of lactation the ducts and the acini dwindle and the stroma increases and becomes firmer; the lobules decrease in size, and many, especially those in the fat-tissue, disappear. Finally, after the climaxis, the metamorphosis is completed, and only the ducts are left, imbedded in the fibrous stroma.

What greater hot-bed can there be imagined for new growths to run riot in than this embryonic structure, with the tremendous hyperplastic and atrophic changes to which it is subjected? At first a stroma, tubules and a few acini, lined by a low grade of cells, protected by a structureless basement-membrane; then a development so rapid and extensive as to infiltrate beyond the limiting capsule; again, a partial disappearance of this newly-formed glandular tissue, only to have the process repeated by subsequent pregnancies; finally, a return to the nulliparous, if not to the infantile, condition!

Equally striking is the metastatic importance of the lymphatic distribution—probably the strongest argument in favor of early, or *pre-malignant* extirpation, as well as against late “tinkering. There are, of course, two sets of lymphatic vessels, the superficial and the deep—the former draining the nipple and skin, the latter the secreting and conducting portions of the gland. These vessels lead in various directions:

(1). To the axillary ganglia and those lying on the outer side of the chest a little lower down; thence to the plexus around the axillary vein, to empty by a duct into the junction of the jugular and subclavian.

(2). Upward over the clavicle into the cervical nodes.

(3). Inward into the anterior mediastinum, on the right side freely anastomosing with the hepatic lymphatics.

(4). Backward into and through the major pectoral, and thence to the side of the chest and axilla, or with the aortic intercostals into the posterior mediastinum and thoracic duct.

This distribution readily explains the dissemination of carcinoma, and occasionally of sarcoma as well, to the axilla, neck, chest-wall, pleura, lung, mediastina, and even to the spine and cord. Liver infection does not need the gravity explanation of Arnold in the venæ cavæ, although, in the cases I have met with, the primary growths have been left-sided. So, too, we can readily understand metastases in bone-medulla and cancellous structure, or a general carcinosis. Again, the fact that

glandular tissue is found outside of the capsule not only opens up possibilities of tumor development in these locations, but shows how readily a growth may infiltrate adjacent tissues through capsular imperfections.

We have, in the breast, tissues from which any tumor may develop:

Thus, a lipoma may originate in the fat overlying or underlying the organ or from that between its lobes; a papillomatous growth can spring from the tubular epithelium, or more frequently from that lining the cysts of adenomata or sarcomata. The abundance of blood-vessels renders possible the formation of an angioma; but, as might be expected, the glandular tumor, the adenoma, or, more correctly, the adenofibroma, on account of the coincident connective-tissue hyperplasia, is more frequent, and the variety of particular interest in connection with this paper. Again, from the supporting network of fibro-cellular tissue may spring a fibroma, although this is almost always a combination growth, as above-mentioned, or more frequently the embryonic prototype of this connective tissue, the sarcoma; but far and above all these neoplasms is the carcinoma, which constitutes more than 80 per cent. of all breast tumors.

Aside from this striking preponderance, there are other points going to make up the gloomy picture of carcinoma. Breast tumors constitute nearly one-fifth of all primary neoplasms, and probably 90 per cent. or more of them are sooner or later malignant. There are fully fifteen hundred deaths per annum, in this country alone, from breast cancer, and the disease is steadily on the increase. A third of these patients die within two years, and fully one-half within three years, after the inception of the disease; the balance do not tarry much longer! Surgical eradication so far presents the most hopeful means of combating cancer, but its lack of success has been due to two principal defects: incomplete operation and delay in operating. The former has been very much improved of late years through a study of the mode of spread. Recognizing skin-infiltration, an attempt was made to excise it with the "dinner-plate" incision of Gross, associated with an attack upon palpable axillary nodes. Finding lymphatics lying in or upon the pectoral fascia, Volkmann insisted that this structure also be cleaned off

the muscle "as for a class-room dissection." But the lymphatic channels connecting the breast with the axilla, where nine out of ten metastases are found, not only pass through the pectoral fascia, but lie, together with numerous glands, in the muscle and under it; and the walls of these vessels, as well as these glands, are found infiltrated with carcinoma. Hence, the complete operation of to-day, of which that of Halstead is a good example, consists of—

(a). Extirpation of the entire breast, together with its two prolongations toward the upper and lower axilla, the offshoot toward the sternum, and any accessory outlying islets.

(b). Removal of all overlying skin, plus a liberal, healthy zone of cutaneous as well as connective and fatty tissue.

(c). Excision of the entire pectoralis major muscle, from its point of origin on the chest-wall almost to its insertion in the arm, with its fascia, of course.

(d). Division of the minor pectoral, and an absolute emptying of the axillary cone, to its very apex, of all fat and glands, not even sparing vessels and nerves, if necessary.

(e). An incision up to the middle of the clavicle to get at the lymphatics under and above the bone.

(f). The induction of primary union, *i.e.*, a minimum of scar-tissue, by suture, flap-sliding, immediate skin-grafting, or the latter after granulations have sprung up, or Schede's moist clot has organized.

The result of this surgical progress has been, first, to make operative interference *permissible*, for an incomplete operation is worse than useless, as it stimulates to more rapid growth the portions left behind; second, to cure a certain proportion more or less permanently, a "cure" being reckoned by the rather arbitrary rule of a three-year immunity. Statistics are not of much value here, because the age of the disease and the metastatic advancement vary, but, in a general way, it may be said that one out of four cases was "cured." It is true that later data, based on the above-mentioned complete operative methods, are sensibly better, but they are even yet rather recent to be absolutely depended upon; and, after all, they, too, leave a proportion of recurrences horrible to think of!

Operative success undoubtedly depends upon the age of the disease and its removal before local and lymphatic spread are beyond the reach of the knife, or distant metastases render the



case hopeless. Attempts have been made to state a period at which secondary manifestations will appear, and six months has been given as the time for axillary involvement, but such theorizing is, to my mind, useless. Here is a case in point, and one of several I have met with:

Mrs. —, 49 years, presented a hard, nodular, movable growth in the upper, outer quadrant of the right breast. There was the not uncommon sympathy with the sexual organs, causing pain at the menstrual period, and this neuralgia kept the tumor constantly on her mind and led her to seek advice. She thought there had been a slight increase in size since the climacteric irregularities had appeared.

Professor Hall's report is about as follows: The growth was made up of stroma and glandular tissue, varying very little from the normal in their relative quantities. A large number of sections from different portions of the tumor presented the same general appearance, with one exception; in this preparation a single duct was found in which the *membrana propria* was imperfect, and a small group of epithelial cells had infiltrated the surrounding stroma. In confirmation of the diagnosis, a gland about the size of a small pea, which was removed with the axillary fat, was found to be infiltrated with epithelial cells similar in character to those surrounding the duct.

Here, then, was a barely beginning carcinoma in a typical, long-lasting adeno-fibroma, which must have gone on almost at once to axillary infection.

The generally accepted signs of differentiation between adenoma, sarcoma and carcinoma are easily summarized:

The adenoma, or more correctly the adeno-fibroma, is a tumor of early life, appearing between puberty and the age of thirty-five years, situated preferably in the upper and outer periphery of the left breast. It is usually hard and lobulated, solitary and encapsulated. Small at first, its growth is very slow, or it may remain quiescent or stationary for years, to increase rapidly under the stimulus of pregnancy or lactation, traumatism or inflammation. Usually painless, there may be distress from sympathy with the sexual organs at the menstrual period, or neuralgia from nerve-pressure, particularly in hysterical patients. Skin involvement is unusual, and when present is due to traction on the lactiferous ducts drawing in the nipple, or pressure from a rapidly-growing tumor, which may even produce sloughing and a curative discharge of the growth.

The main characteristic of adenoma, however, is its mobility. While the lymphatics are not enlarged, they may be tender.

The cystic variety, the cyst-adeno-fibroma, or the *adenocoele*, occurs usually later in life, say between the years of thirty and fifty. It consists of dilated acini, lined with epithelium which may proliferate to produce papillomata. Aside from the characteristics of a cyst, the adenocoele is usually more centrally located than the solid variety.

The sarcoma is a tumor of middle life, thirty to fifty years, beginning usually as a small, solitary, smooth nodule, preferably in the central portions of the left breast. While usually growing rapidly, it may remain quiescent for long periods. Its consistency necessarily varies, according to the preponderance of the cellular or fibrous elements, but it shows a strong tendency to become cystic, papillomata growing into these cavities, and being associated with hæmorrhages which cause rapid accessions in size—the so-called “malignant blood cyst.” Encapsulated as a primary growth, recurrences or advancement soon soak into the surrounding tissues. Hence skin attachment follows not only from infiltration, but from pressure, with consequent sloughing and the characteristic fungation. When nipple retraction is met with it is due to duct traction, and while lymphatic spread is occasionally noticed in the round-celled variety and the adeno-sarcomata, as a rule metastases follow the usual course, the circulation.

Carcinoma slightly favors the left breast, too, and the periphery of its upper, outer quadrant. It is met with, of course, at the “cancer age” principally, forty to sixty years, and is usually hard and freely movable at first, and apparently encapsulated, even if not preceded by its frequent prodrome, the adeno-fibroma. As the disease progresses, there develop the characteristic signs of carcinoma: glandular involvement, usually first noted in the axilla, although such infection is necessarily preceded by that of the pectoral glands and vessels. Nipple retraction is present in a certain number of cases, but not nearly as frequently as is generally supposed. Far more common is the skin attachment, appearing as a dimpling or puckering, and finally as a shotty infiltration and subsequent ulceration. Then follows immobility, which becomes more and more characteristic as the growth glues itself to the chest-wall. Incidentally might be mentioned the late-appearing cachexia, the rheumatoid aches in the cancellated bone (manubrium sterni, humeral head, vertebral bodies, femoral shaft, etc.), which indicate distant metastases, and last, but premeditatedly least, the much talked of, too long-looked for, “cancer pains,” which, when present, are only of the gloomiest prognostic value.

Comparing, for a moment, the characteristics of these three commonest mammary tumors, it is very evident that when we can distinguish carcinoma and sarcoma from the solid or cystic adenoma, malignancy must be sufficiently established to impair the patient's chances of recovery to a very marked degree. Thus axillary nodes, skin infection and immobility from attachment to the chest-wall, while settling the diagnosis of carcinoma, also settle, in the order of their enumeration, the patient's fate. So, too, rapid growth, cystic or solid, skin infiltration, ulceration and fungation would lead us to make a clinical diagnosis of sarcoma. But what chances of permanent cure can we offer the patient? Dr. Hall goes so far as to believe, from a pathological standpoint, that no adenoma is benign, and I think he is about right—its benignity being evanescent, and its malignity, alas! too frequent!

After all, with the most approved methods of operating, we still find but one in four, or, to be more generous, 40 or 50 per cent. of "cures." This can only be improved by applying energetic surgical measures to a sarcoma or carcinoma when it *resembles* an adenoma, or, better still, to remove the latter before giving it a degenerative opportunity! The same prophylactic surgery should be applied to breast cysts, whether they be of the involution, duct, hemorrhagic, or even of the serous variety. If not a part of a malignant growth, their tendency, with the exception, perhaps, of the last-named, is too often in this direction. This is equally true of the nipple and areolar eczema, for which none of the ordinary causes can be found, and which persists in spite of ordinary treatment; for Paget's disease is but one of the prodromata, if it is not a first stage, of carcinoma. Nipple discharges also, without physiological reason, should be viewed with suspicion and their origin attacked, if found.

Let me illustrate with a few cases:

Mrs. —, age fifty years, multipara, had noticed for some years a centrally located nodule in the right breast. Its growth had been very slow until a recent accession, due evidently to cyst-formation. A complete operation was done, and Dr. Hall reported the tumor to consist of a diffuse overgrowth of connective-tissue, with dilatation of the milk ducts; into their lumen projected polypi, composed of fibrous and myxomatous



tissue and covered by the epithelium lining the ducts. In other places, instead of being dilated, the ducts were surrounded by a thickened, cylindrical investment of connective-tissue, which was infiltrated in spots with a large number of small, round, embryonic cells, adding a sarcomatous element to the tumor.

Diagnosis: Intra- and peri-canalicular fibroma, combined with myxo-sarcoma.

Miss —, 22 years old, presented a small nodule on the outer side of the left breast. Contemplating marriage, and suffering considerable pain at the menstrual periods in the lump, she sought advice. In view of the prospective stimulus of pregnancy and lactation operation was recommended, and the growth removed without injuring the mamma. An incomplete operation was done, because the tumor was absolutely distinct from the breast, being probably an outlying islet or one of the axillary offshoots. Without multiplying details, the growth proved to be a typical adeno-fibroma.

Mrs. —, age 58, had had for years a hard, movable, stationary or very slowly-growing lump in the upper periphery of the left breast. Rapid accession had taken place within a few months. A complete operation was done, and the original nodule found to be a typical scirrhus, while the "periphery consisted of long streaks of large epithelial cells with scarcely any fibrous stroma."

Diagnosis: Long-dormant scirrhus, with recent encephaloid development!

We have still to consider the causative relation of inflammation, statistics showing that considerably over 10 per cent. of carcinomata are traceable to traumatisms, and nearly one-third of them to a preceding mastitis. When we remember the analogy between cicatricial tissue and the stroma of carcinoma, and the frequency of scar recurrences, the predisposition produced by infectious or traumatic, acute or chronic inflammations, is readily appreciated. So, too, has the stimulus of such processes an important bearing on pre-existing glandular growths.

The following cases are in point:

Mrs. —, 65 years, had a suppurative mastitis of the left breast with the birth of her last child, now a mother. A hard lump had persisted, which had begun to grow within the past year. A complete operation was done, and the tumor found to be composed of large and small cell-nests, round and oval in form, surrounded by an abundant stroma, dense in character.

In many of the nests the epithelial cells near the centre had undergone degeneration. The axillary glands showed the same general character.

Diagnosis: Carcinoma simplex, developing in the cicatrix of an ancient mastitis.

In contrast with the above is the following:

Mrs. —, aged 72, presented a similar history of mastitis, her youngest child being thirty-seven years old. The cicatricial nodule had been growing for about eighteen months until the disparity between the two breasts was noticeable through the clothing. The tumor was attached to the skin, but not to the chest-wall. An albuminose, viscid discharge from the nipple had been noticed, which dried and formed a scab, and there was a slight but persistent eczema of the areola. The nipple had been retracted since the mammary abscess healed. A complete operation was naturally done, and a number of axillary nodes removed with the fat, but Dr. Hall's report was entirely different from what I had reason to expect. The breast was composed principally of adipose tissue, firm and intensely yellow; while stretched, the capsule was intact throughout. Imbedded in the fat were numerous ducts, lined with atrophic, columnar cells, but the acini had entirely disappeared. The axillary glands, enlarged to a marked degree, were composed principally of fat, which was apparently supplanting the lymphoid tissue, as in the breast.

Diagnosis: Adipose metaplasia.

How are we to distinguish these tumors before operating? Of two other cases, in the one a similar nipple discharge, persisting for months, was found to originate in a duct-cancer, while in the other an eczema—more characteristic, it is true—was associated with indurative bands leading into a like growth.

As illustrating the effects of traumatism in tumor formation, the following cases may be cited:

Miss —, age 29, consulted me for a steadily-growing, hard lump in the outer and lower quadrant of the right breast, which had developed after a severe bruise. Excision was advised, and, as she was soon to be married, the incision was made in the crease below the breast. A hard outgrowth was found intimately connected with the gland, which, for this reason, was completely removed, leaving the nipple in place. The discrepancy was not very noticeable, as her breasts were small. At her urgent request, the axilla was not opened, a complete

operation having been consented to if a microscopic examination showed malignancy. This was, however, unnecessary, as the tumor was demonstrated to be adeno-fibroma. Complete removal of the gland was advisable, in my judgment, because it was impossible to enucleate the growth.

Miss —, about 25 years old, was struck on the right breast a few months before being seen. The gland had grown so rapidly and with such pain, redness, etc., as to lead to the diagnosis of abscess. Incision showed a soft, infiltrating tumor, and a complete operation was accordingly done, although no palpable axillary nodes were recognized. The microscopic diagnosis was *encephaloid*: "The tumor was soft, and contained an excess of epithelial elements; the cells were large, with distinct nuclei; the nests were of unusual size and oval in shape, many of them showing areas of degeneration. The stroma was scanty in comparison with the epithelial elements, and in many places was itself infiltrated with round, inflammatory cells. One gland found in the fat removed from the axilla showed the same general structure."

As demonstrating the stimulus of inflammation on breast tumors, and on account of its pathological rarity, I will add one more case to the above:

Miss —, 37 years old, presenting a marked kyphosis from a healed Pott's disease of childhood, consulted me for a hard, nodular, freely-movable tumor in the upper, outer quadrant of the left breast, which had existed for some years, but which had recently begun to increase in size. Associated with this was considerable pain in the gland and a general enlargement. This latter was irregular in character and due to a number of elastic, smooth nodules. Several tender axillary lymphatics were easily made out, as she was exceedingly thin. When operated, a week or two later, the entire breast was swollen and tense and fluctuated in spots, the original tumor being obscured. After removal it was found to be riddled with cold abscesses, containing "thin, lumpy pus." The tumor consisted of acini, the *membrana propria* in many being imperfect, the cells infiltrating the connective-tissue stroma. In the latter were found a large number of typical military tubercles, some with caseated centres. *Tubercle bacilli* were easily demonstrated. The axillary glands were also tubercular.

Diagnosis: Adenoma, degenerating into carcinoma; breast and axillary tuberculosis.

It seems to me that we can sum up our duty in regard to the pathological conditions met with in the breast, as follows:



Operations for malignant disease, no matter how complete, show an appalling recurrent mortality. These recurrences preclude all discussion of the cosmetic question of mutilation, as well as that of operative mortality. The latter is only possible after delay and in the presence of complications which should contra-indicate any surgical procedure. As to the former, I say, let us mutilate a few more women, and see fewer die an agonizing death from that accursed rival of tuberculosis—"cancer."

It is impossible to distinguish malignant from benign mammary tumors in time to prevent this recurrent mortality. For practical purposes, then, all mammary nodules or *lumps* should be excised by a complete operation, either primarily, according to the judgment of the surgeon, or subsequently, if a microscopical examination shows malignancy.

The same is true, to a slightly modified degree, perhaps, of inflammatory products. Traumatic nodules are better out than in, the thoroughness of the excision being dependent on their supposed or demonstrated character. The results of suppurative processes must be treated according to the amount of destruction and subsequent cicatricial-tissue formation. The only function of a breast ruined by a riddling mastitis is to invite malignant growths. The remnants of a less destructive suppuration are equally dangerous. A tubercular breast to-day is removed by a complete operation. If chronic interstitial mastitis be a possibility, it is more than likely a beginning malignant tumor or, at least, its prodrome. This applies with even more emphasis to Paget's disease, which always calls for prophylactic amputation.

---

THE CEREBRAL SYMPTOMS OF SANGUINARIA CANADENSIS.—Dr. Koop experimented with this drug, taking 50 egms. of the mother-tincture eight or nine times a day for two weeks, producing a great variety of cerebral symptoms, evidencing its usefulness in certain cerebral diseases, as vertigo, migraine, headache, rheumatic, congestive and climacteric dyspepsias or those due to suppression of the menses, and notably if there be nausea or bilious vomiting. He also recommends it in hæmorrhage into the brain, if there be weakening of sight, tension of the temporal veins, vertigo, burning of the stomach and vomiting.—*Journal Belge D'Homœopathie*, No. 2, Vol. V.

HOW CAN THE TEACHING OF THE SPECIALTIES IN THE UNDER-GRADUATE COURSE BE MADE TO SERVE ITS TRUE AND BEST PURPOSE—THE QUALIFICATION OF THE STUDENT FOR GENERAL PRACTICE?\*

BY JAMES C. WOOD, M.D., CLEVELAND, OHIO.

Professor of Gynecology in the Cleveland Homœopathic Medical College.

It is difficult to discuss the subject assigned me without first briefly considering some of the peculiar features of medicine which distinguish it from other sciences.

We in America are so intensely practical as to make us oft-times loath to indulge in retrospection. We are ever seeking the short cut, dealing always with the present, and almost never with the past. There was some excuse for this in the days of short terms and two-year courses; but this excuse is no longer valid, now that four years is required by all homœopathic colleges.

While I recognize that the four-year course has been made necessary by the large number of practical subjects which, during the last ten years, have become a part of medicine, I nevertheless believe that the extended time now required is ample to teach the student something of the history and evolution of medicine. None other of the learned professions omits such instruction. What would be thought, for instance, of a theological school which would plunge its students headlong into the dogmas of its particular sect without first dealing with the history of religion or religions? Such a school would be very narrow indeed; and yet, gauged by the same rule, medicine is even more narrow than theology. I believe that if every college in the country were to provide for a thorough course of instruction in the history of medicine, showing how it has gradually evolved a literature far too vast to be mastered in all of its departments by one mind, specialism would be broadened because of the knowledge thus disseminated.

It is entirely without the scope of this essay to review, even

---

\* Read before the Semi-Centennial Celebration of the Hahnemann Medical College, Philadelphia, June 11-12, 1898.

cursorily, the medicine of the past. Suffice it to say that such a review would place medicine without the domain of the sciences—certainly without the domain of the actual sciences—if, indeed, we accept the definition that a science is “a complement of cognitions, having in point of form the character of logical perfection, and in point of matter the character of real truth.”

It will hardly be claimed by the most ardent believers in the law of similars that that law conforms to the requirements of the definition given, although I believe that it is the only law of cure which even approaches such conformity. On the other hand, it must be admitted that medicine embraces many of the sciences which are nearly, if not quite, exact. Microscopy, biology, chemistry, bacteriology, pathology, physiology and anatomy are now comprehended by the term medicine; yet even by the aid of all these, and much more, we are able, in our efforts to comprehend that which pertains to the essence of life and the dissolution of living beings, which we call death, to penetrate little beyond structural appearance and functional phenomena. We know, for instance, that the brain is composed of white and gray matter; that the brain tissue is made up of so-called nerve corpuscles, which function, according to Andriessen, by means of actual contact; that the corpuscles, in turn, are composed of cells arranged in layers of four in number, each of which doubtless has a special function to perform. We are even able to localize function as regards both sensation and motion—this much has anatomy, physiology and histology taught us. When, however, we come to the localization of mental faculties we are yet at sea, and still grope our way in darkness. And so it is with much more that pertains to medicine, especially to the primal and ultimate facts—the beginning and the end of life. I claim that the uncertainties which characterize medicine, and especially therapeutics, should be presented to the student early in his career, that he may not be turned loose from college with a sublime faith in all that has been taught him. In making this statement I trust that I shall not be classed a therapeutic agnostic, for I am not. In the broader meaning of the term, therapeutics (*materia medica*) is but a small, though important, part of medicine. The medicine of to-day is but a consummation of nearly all that is good



(and much that is bad) of the medicine of the last six thousand years. No school or sect has a monopoly of it. No sharp line of demarcation separates the medicine of to-day from that of yesterday, and the student should have this fact impressed upon him. This much should be taught him before he enters upon specific instruction in any of its special departments. He is then prepared to study the phenomena of disease, and to form reasonably intelligent conclusions from the facts and data given him. He may, and probably will, possess a *penchant* for some particular department of medicine; but he will constantly bear in mind that the heresies of yesterday are the accepted facts of to-day, and that the heresies of to-day may be the accepted facts of to-morrow. This knowledge will make him ever ready to investigate new truths, and at the same time keep him from chasing every *ignis fatuus* which appears in the medical horizon.

Notwithstanding that specialism has been, and is now, abused, no one, I think, will deny the advantage of specialism. Humanity has been immensely benefited by the division of the body medical into specialties. I believe, however, that the ordinary conception of the specialties is too narrow. As I understand it, the man who teaches *materia medica*, or devotes especial attention to its study, is a specialist in therapeutics quite as much as is he who devotes his time and energies to the study of renal affections a specialist in kidney diseases. The general practice of medicine is likewise one of the most important of all specialties. Surely one who is in constant contact with the so-called general diseases, and has made an especial study of them, is infinitely better prepared to treat an enteric fever than is the oculist or gynecologist who rarely, if ever, sees a case of enteric fever. It is true that the general practitioner must and should have at least a fair knowledge of all the departments of medicine; but it is equally important that the specialist should possess at least a general knowledge of all diseases. Unless he does, he can observe little beyond the focus of his ophthalmoscope or the field of his speculum, and is ill-fitted to do his part toward making of the undergraduate a broad general practitioner.

In medical teaching the natural tendency is for each lecturer to give to his department an exaggerated importance. It is

perhaps well that this is so, because it bespeaks enthusiasm on the part of the lecturer, without which he cannot make a successful teacher. If all chairs are filled by men equally enthusiastic the tendency to overestimate the importance of this or that chair can do little harm, unless, indeed, some individual teacher so outshines his colleagues in eloquence, or in brilliancy of technique, as to enable him to mislead his class, wittingly or unwittingly. It is to be admitted that the surgical chairs have an immense advantage over the non-surgical in that the glamor attending a modern surgical operation, with its immediate results, impresses the undergraduate far more vividly than does a cure by internal medication, even though the latter may require greater skill and be infinitely more scientific. Fortunately, the average medical student is no fool. As a rule he becomes, by the time he reaches his senior year, a keen observer, and can readily distinguish the spurious from the genuine. If an opportunity is afforded him, as it should be, of following up the cases presented for his instruction, his conclusions will be largely formed by the results obtained, and, as a rule, correctly formed. An operator cannot long play to the galleries alone without exposing his methods to the boys on the front seats, and in the end his teaching will be rated according to its true value. Nor will the man who can see nothing beyond the "indicated remedy" fare better. If the clinician in the exclusively therapeutic chair is unable to distinguish a headache due to asthenopia from one of a purely functional character; or prescribe indefinitely for a supposed ascites when the abdominal distention is due to an eighty-pound ovarian tumor; or causticum for dribbling of urine due to bladder distention; or persists in treating by internal medication alone obdurate nausea and vomiting due to ovarian impingement; or does not discover why his arsenicum or gelsemium fails to control a fever due to pent-up pus; or permits carcinoma to become inoperable while following the lead of a blind symptomatology, he must expect his students to lose faith both in him and his teachings. These are more than word-pictures; they have been drawn from a personal experience which has convinced me that the sins of omission on the part of the general practitioner are quite as great as the sins of commission on the part of the specialist.

How, then, shall we avoid, in dealing with the undergraduate, this one-sided teaching? My answer is this: *He should be taught, from the inception of his medical course to its very end, that there is a totality of the organism as well as a totality of symptoms; that there is no organ of the body independent of its fellow or fellows; that all are connected anatomically and physiologically, and that disease or lesion of any one may, and frequently does, disturb other and distant organs.* Besides, he should become thoroughly imbued with the idea that the mission of the physician is, first, to prevent disease, and, second, to cure disease which he cannot prevent, in the easiest and safest possible manner—by internal medication if possible, by other methods if necessary. He should be given an abiding faith in therapeutics; but he should likewise be taught the limitations of the internal remedy, so that each case which presents itself for treatment will be studied from a diagnostic and pathologic as well as a therapeutic standpoint. If he be thus equipped, there is little danger of his becoming either an extremist in therapeutics or a pure localist. He will be a true physician in the highest sense of the term—a safe man to entrust with the lives of his fellow-men.

I should be incompetent, even if the time were granted me, to deal with other specialties than my own from the standpoint of a teacher. It is my aim in teaching gynæcology to lead the student on step by step, first dealing with the foundation principles of the subject, without which he is utterly unfit to proceed farther. That he may ever look for removable and preventable causes, a lecture or two are devoted to the ætiology of gynæcological diseases. That he may be able to distinguish diseased from normal structure, the special anatomy of the female pelvic organs is carefully reviewed. At least one lecture is devoted to "case taking," in which the significance of pain is carefully considered under the heads of "location," "function" and "posture." In this lecture I endeavor to teach the student how to obtain the clinical history, both for the purpose of diagnosis and prescribing, at all times emphasizing the fact that subjective phenomena alone cannot be relied upon in diagnosis. To my mind there is no more important point than this in the whole domain of medicine. Serious organic disease is so frequently insidious in its character that un-



less the physician is ever on his guard it will have advanced to an incurable stage before being discovered; whereas simple functional disturbance may, in another woman, give rise to numerous and distressing symptoms. Another lecture is devoted to the "significance of the discharges" in diagnosis, especial stress being laid upon their significance in malignancy. I endeavor, in this lecture, to impress the student with the fact that the discharge is but a symptom of *something wrong elsewhere*, and that that "something" may be either constitutional or local, or both. The importance of the microscope as a means of diagnosis is also considered. At least three lectures are devoted to the methods and means of physical diagnosis. These are followed by one devoted to the "general pathology of gynecological diseases," which I deem the most important lecture of my course. In it I endeavor to show not only the intimate connection existing between all of the pelvic organs, but the unity of the entire organism. I endeavor to show how distant organs are involved in a reflex way, the nature of the local lesion causing reflexes, and the manner in which local diseases are caused by general disturbances. Attention is likewise directed to the temperament and constitutional bias as factors in the creation of both general and local diseases. No student can pass my chair without a thorough knowledge of this subject, and when he is done with it I have little fear of his relapsing into a mere localist. From general pathology I pass to the "general treatment of gynecological diseases," taking up seriatim those general measures so useful in indigestion, constipation, nervous prostration, etc. Another lecture is devoted to "local treatment," due consideration being given both to the use and abuse of local measures. Electricity as a therapeutic measure in the diseases of women is carefully studied. Finally, one or more lectures are devoted to the principles of antisepsis and asepsis—without a thorough knowledge of which no physician should be permitted to enter upon the practice of medicine.

The student is now ready to consider disturbed function and diseased entities. Personally I prefer to begin with the so-called hystero-neuroses, because a study of the neuroses necessitates incursions into the fields of anatomy, physiology and psychology—whose study tends both to broaden the specialist

and emphasize the solidarity of the organism. The knowledge he will have acquired in these preliminary lectures will enable him to understand the importance of combining general and local measures in the treatment of the diseases that are to follow—the drug indications for each disease of course being given.

A student thus taught ought to be a good diagnostician, a good pathologist and a good prescriber—the three attributes which constitute, so far as mere technical knowledge is concerned, the essentials of a successful general practitioner.

I believe that all of the specialties can be handled in much the same way, the sum total of the knowledge thus acquired making of the student a broad and liberally educated physician.

---

### CLINICAL LECTURE.\*

BY CLARENCE BARTLETT, M.D., PHILADELPHIA.

(Delivered February 3, 1898, at the Hahnemann Hospital, Philadelphia.)

CASE I.—EPILEPSY.—The first case to which I invite your attention is that of a young man aged 19 years, who follows the occupation of a clerk. His father is living, and is in most excellent health. His mother died of cancer of the stomach. He himself has enjoyed good health until recently. Last June he began with convulsions, which would come on suddenly, and in which he would fall in tonic and clonic spasms. The paroxysms were attended by loss of consciousness, which sometimes lasted for several hours after the convulsive movements ceased. The spasms themselves lasted but a few minutes. Since last June, he has had a recurrence of the convulsions at various intervals. Sometimes they would come at intervals of six or eight hours, and at others they would remain away for two or three weeks. Between the attacks he is absolutely without symptoms. Physical examination of the head, trunk, extremities, gastro-enteric organs, respiratory and nervous systems, the special sense organs, and the urinary apparatus, show

---

\* Reported by F. E. Wessels, Medical Stenographer.

the boy to be absolutely well aside from his convulsive seizures. On June 17th he was taken with these convulsions with remarkable frequency; indeed one followed so closely upon its predecessor as to make the paroxysms continuous. It was in this condition that he was first brought into this hospital. Under treatment the attacks subsided; they became less and less frequent until at last he was dismissed from the hospital, —improved, not cured. As already stated, the attacks continued at varying intervals. A few weeks ago he was re-admitted in the same condition as he presented in June. Now I suppose all of you have made up your minds as to the diagnosis of the case, and the probabilities are that all of you have diagnosed the case correctly. Our diagnostic data are convulsions of short duration, consisting of tonic and clonic movements, attended by complete loss of consciousness, coming on suddenly, and in a young man who is otherwise in the best of health. The case can only be one of epilepsy. It differs from most cases of this disorder, however, in the remarkable tendency to periods during which the seizures follow closely upon each other,—a condition which we know as the *status epilepticus*, and in which he was on both occasions of admission to the hospital. You all have heard me speak of the status epilepticus in my didactic lectures. You therefore know it to be a condition in which epileptic paroxysms follow so closely upon each other that there is no intervening period of consciousness; in many cases there is a remarkably high temperature. I have seen fatal cases in which the thermometer recorded a rectal temperature of 108° F. It is needless for me to remind you that the status epilepticus is very dangerous to life. When, therefore, the patient was admitted it was necessary that something be done promptly. He was unable to swallow, so all medication was given by rectum. The same drugs that are useful in the treatment of epilepsy are useful in the status epilepticus. We gave this patient bromide of potassium 20 grains, chloral hydrate 10 grains, in 4 ounces of water, by the rectum, every four hours. After this treatment was instituted the convulsions gradually ceased, and as soon as the young man regained consciousness, medication by the mouth was substituted, and we gave him bromide of strontium instead of the potassium salt. You all know that I am a most earnest advocate of the bro-



mide of strontium in the treatment of epilepsies as opposed to the use of any other bromides. The reason I like the bromide of strontium is that it does not tend so readily to disorder the stomach as does the potassium salt, and, moreover, the patient does not appear to so readily take on the symptoms of bromism. An experience of over four years with this drug leads me to say that I have as yet failed to meet with any deleterious results from it. Let me say, however, that I exercise discretion as to the cases in which I prescribe bromides, and I am always particular as to the brand of drug I administer. It is essential that the drug used be pure. It is said that strontium salts as found in commerce are liable to contamination with barium salts, and these are poisonous. For a long time I used only strontium bromide manufactured by Paraf-Javal, as being the only one which I believed to be chemically pure. Later I learned that I could also rely upon that manufactured by Merck, of Darmstadt, and as this was much less expensive, I have employed it exclusively ever since. When administering bromide of strontium it is always best to dispense a saturated solution, one minim of which will contain about three-quarters of a grain of the crude drug. Always order that it be given after meals, and very freely diluted with water. Our patient is taking 1 drachm of the saturated solution (equivalent to about 40 grains of the crystals) three times daily. You can see his condition for yourselves. There is no mental hebetude, no skin eruption or other evidence of bromism, and he declares himself as feeling in first-class physical condition and anxious to return to his home.

As to the future of this case it is difficult to prophesy. Under the best of circumstances the outlook for epileptics is not promising. The majority under careful hygienic and medicinal treatment are improved, but few ever attain a radical cure. I feel that this particular case offers a less favorable prognosis than the generality of cases because of the early period in the course of the disease in which the status epilepticus appeared. Such a condition is suggestive that there exist pathological changes which are not recognizable in the present state of medical knowledge.

NOTE.—This patient continued to do well for three months, when the status epilepticus recurred. Prior to his relapse he

began to suffer from severe headaches, which continued after the subsidence of the convulsions. Otherwise his symptoms remain unchanged. There were no optic nerve changes, and his knee-jerks continued normal. It now seems likely that the epilepsy in this case has an organic basis.

CASE II.—JACKSONIAN EPILEPSY.—The next case that I bring before you is likewise one of convulsions. He is a young man aged 32 years, following railroading as an occupation. His parents are living and well; he has one brother and one sister, both healthy. His grandparents on both sides were long-lived; hence the family history is a most excellent one. He himself has suffered from most of the diseases incident to childhood. He had inflammatory rheumatism twelve years ago; he contracted syphilis in 1892. The present illness began two years ago. Remember that the syphilitic infection took place six years ago. The first symptoms were gastric in origin. Milk was about the only article of diet that could be retained in his stomach, and even this was not infrequently vomited. His bowels did not move unless stimulated to action by enemata. Shortly after this his right hand was drawn upwards (dorsal flexion) and fixed in this position. Then the arm became so sensitive that even a fly alighting upon it caused it to jerk or jump. Then there began twitching of the right hand and arm; later the movements extended to the leg. He has more or less constant pain in the left parietal region. Physically we find but little wrong. I have examined his eyes, and find his pupils reacting normally to both light and accommodation, and there are no changes visible to ophthalmoscopic examination. With the dynamometer he exerts a pressure of ninety-five degrees with the left hand, and but forty degrees with the right. As he is right-handed he should show a stronger grip with the right hand. Usually we find the normal difference in the grasps of the hands to be from ten to fifteen degrees. Here the right hand is fifty-five degrees weaker than the left. We know, therefore, that there is some loss of power. I next proceed to examine his knee-jerks. Please notice that a very slight tap on the right ligamentum patella is sufficient to produce a very energetic jerk; I find the same to be true on the left side, but you can see that the response of the left leg is less energetic than that of the right. The convulsive paroxysms

come at intervals of about a month, and are not associated with loss of consciousness. Here then is our case: Syphilitic history; localized convulsions without loss of consciousness, the convulsions now being limited strictly to the right hand and arm; some soreness of the head forward of the fissure of Rolando; no optic neuritis; no pupillary disturbance; greatly increased knee-jerks, especially noticeable on the right side. Our diagnosis should include an opinion as to the pathological lesion and also as to its location. Our patient is a young man aged 32 years. He should, therefore, not be liable to lesions which occur during the degenerative period of life. There is, therefore, a likelihood of some other cause for his illness. I have repeatedly said to you in my didactic teaching that the vast majority of organic brain affections occurring in young adults are syphilitic in origin. His age is therefore presumptive evidence of syphilis. We are fortified in our suspicions, however, by the knowledge that our patient contracted syphilis four years before his present illness began—a period sufficiently far back to have given the syphilitic poison time to wreak its vengeance on the brain. While it is easy to say that the trouble is in all probability syphilitic, the structural character of the lesion cannot so readily be discovered. It may be a gumma, or it may be a localized meningeal change, or it may be a meta-syphilitic lesion. It would be a matter of mere chance should I make a correct pathological diagnosis as to the structure of the lesion. But as I have said before, I think that we can give the cause with great certainty, and this, for therapeutic purposes, is about all we need. You know what I mean. You have doubtless guessed that I shall place this patient upon iodide of potassium in material doses, and you have guessed correctly.

This patient has, however, already been subjected to a course of iodide of potassium, and judging from his description it was judiciously directed. Experience has taught me, however, to take nothing for granted. Time after time have I encountered cases which have taken certain remedies, but which have not recovered under their administration, and yet afterwards I have seen recovery proceed without interruption under their use. With no remedy is this more frequently observed than with iodide of potassium. The errors seem to arise mainly in the failure to prepare a properly saturated solution or to ad-



minister full-sized drops. The fact, then, that our patient has already passed through a course of iodide of potassium does not deter me, though it does somewhat shake my faith as to the possibility of securing good results from medication.

You must also bear in mind that iodide of potassium sometimes fails to cure cases of nervous disease arising from syphilis. This is because the primarily specific lesion has set up secondary changes which are non-specific pathologically. It may be the case that the iodide treatment already instituted has done away with the primary lesions, the secondary ones remaining. Should the course we are about to institute fail in bringing about a good result, we must devise other measures for our patient's relief or cure. His lesion is undoubtedly a local one. The convulsions limited to the arm, associated with loss of power in that member and unattended by loss of consciousness, attest that fact, and demonstrate that the pathological changes are situated in the middle-third of the convolutions about the fissure of Rolando, on the left side; that is in the middle-third of the so-called motor area. If medicine fails, I shall advise an exploratory trephining. It will depend upon what we shall then discover as to our subsequent course.

NOTE.—The iodide treatment was maintained for about one month without any benefit whatever. The spasms came on worse than ever, until clonic movements of the right hand and forearm were practically constant. Dr. Van Lennep then operated. The trephining discovered marked œdema over the exposed area. This was relieved by drainage. The spasms ceased at once. The headache disappeared, and the patient has remained well.

CASE III.—JACKSONIAN EPILEPSY.—The next patient that I bring before you was formerly a private patient of mine. As her means did not permit her to have the attention at home that her case demanded, I advised that she place herself under our constant supervision in the hospital. She first came under my care on the 18th of December, 1897. She gives this history: On May 14, 1897, she became very much overheated. Her mother is a very careful woman—altogether too careful. Indeed she would, if permitted, kill her children with too much care. Although May 14th was a very hot day, this young woman was wearing her usual winter underclothing,

such as would be necessary on a day like the present. It was on this day that she was overcome with the heat, and then she was taken with jerking of the right arm. Then she declares that she became paralyzed. She became unconscious, remaining so for twelve or fifteen minutes. The convulsion did not last more than five minutes, and consisted of tonic and clonic spasms. (The notes that I am reading are rather disconnected, because I am reading them to you as I got the facts from the patient and her father.) Since the first seizures she has felt her face twitch at times; it is only the right side of the face that twitches. She does not admit that the right arm is weaker. After the first convulsion, however, she has always supported the right arm with the left. She declares that she has continued to use the right arm as much as possible, seeming to think that this meant as much as formerly. My observations tell me that she uses the right arm only when she is obliged to do so. The dynamometer shows the grasp of the right hand to be twenty-five degrees; the left, forty degrees. Both knee-jerks are exaggerated, neither one more so than the other. Her pupils are large, and react normally to light and accommodation. The margin of the right optic disk is slightly hazy, but I hardly think is to be regarded as possessing pathological significance. Her tongue is coated and pasty; breath is highly offensive; so much so in fact as to be noticeable several feet away. Her bowels are constipated. In view of the pasty condition of the mouth, the offensive breath, and the constipation, there can be no doubt of the existence of digestive disorder. I have placed her on *nux vomica* and exclusive milk diet. Under this treatment her digestion has improved, so that now her stomach may be regarded as practically well.

When this girl walks about she does so as if she was afraid of hurting herself, particularly in the right arm; and yet inquiry does not show that she has any pain or sensitiveness in that locality. It seems really that this peculiarity is a habit. This, together with the illy-judged care and attention on the part of the mother, has suggested to me the possibility of the case being one of hysteria. But the other clinical phenomena are decidedly opposed to any such hypothesis. The localized spasms of tonic and clonic character, and the limitation

of the succeeding paralysis to the arm, lead me to diagnose a cerebral lesion localized in the middle-third of the motor area; that is, in the middle of the convolutions bordering on the fissure of Rolando. As to the character of the lesion, we have no data on which to base an opinion. We cannot say that it is a tumor, for there is neither headache nor optic neuritis. We cannot say that the case is one of abscess, because neither of the prominent causes of abscess, middle-ear disease and injury, has entered into the history of the case. It is suggested that the abscess may be tuberculous. Examination of the patient fails to show any evidence of such a condition in any portion of the body. There is no specific history, and, moreover, the clinical phenomena are not suggestive of syphilis. Hence we can eliminate that. There must, however, be some organic change to produce these symptoms, and this change must be of an irritative character. The sudden onset in the midst of apparently good health indicates a vascular origin. With this we must remain satisfied.

Having decided that the lesion is local, what shall we advise as to operation? While, of course, we might go ahead and operate, and thus cure the girl, the case is so obscure that we are not warranted in adopting any such radical treatment. At present we have no assurance that the lesion is an operable one. Moreover, her symptoms are by no means urgent, and her physical condition is better than it was a month or so ago. It is better, then, to let things take their course for awhile. If she continues to improve, all well and good. If she relapses, the new symptoms that will develop will probably enable us to act more intelligently than we can at the present time. Her stomach is now in good condition, and our treatment is to be directed only to preventing or lessening the recurrence of the attacks. For this purpose, we will give her bromide of strontium in 15-drop doses of the saturated solution.

NOTE.—This patient has continued under personal observation since the above remarks were made. She has had no convulsions since early spring, although there is still some weakness of the right arm and hand.

CASE IV.—*SYPHILITIC BRAIN DISEASE, symptoms following closely upon traumatism.*—This patient is a woman aged 33



years, a seamstress by occupation. Her father is living but suffers from bronchitis. Her mother died of asthma or bronchitis, so she says. She had one sister who died from an accident, and one brother living and well. She has no children. She was well until a little over a year ago, when she fell and struck herself severely on the pavement. Two weeks after this she lost power over the left arm, notwithstanding at the time of the accident she did not think that she had hurt herself to any extent. The paralysis increased in extent and involved the whole left side of the body. In June, 1897, she began to see double. At present there is a slight divergent squint. Vision of the right eye is very bad, owing to optic nerve atrophy. I saw her for the first time about the middle of January. She was then able to walk. Her knee-jerks were then greatly exaggerated. Since then she has grown rapidly worse. On January 25th she was admitted to the hospital, with complete paralysis of both arms and both legs. Notice now the condition of her hands. This, the left, is the side first attacked. It is greatly contracted. The right hand is also deformed from the same cause, though in less degree. This, then, is the case. Her husband denies syphilis. This case involves some very important medico-legal questions. Already a jury has passed on it and awarded her heavy damages. We have a history of injury followed in two weeks' time by a serious set of symptoms, and these symptoms have taken on periods of exacerbation since that time. Certainly it is very unusual for an injury to act in this way, although it is not impossible for it to do so. On the other hand we have suggested the possibility of a syphilitic trouble. You have repeatedly heard me say to you that the association of ocular palsy with hemiplegia in young adults is almost pathognomonic of a syphilitic cause, and to furthermore impress this idea upon your minds I have said that if a patient presenting this set of symptoms swore upon a stack of Bibles as high as a church steeple that he had never had syphilis, I would not believe him. There can be no harm in putting this theory to the test in this case. If the symptoms are due to traumatism, the brain is irreparably damaged. If the lesion is syphilitic, we may do considerable for her with iodide of potassium. She has been taking the drug since her admission to the hospital, and is already better. In fact, within

ten days of the time of admission there is improvement in a case that had been going rapidly from bad to worse. I believe really, that notwithstanding the apparent relation of the accident to the symptoms, that traumatism had nothing to do with the case, unless it may have acted as a "hastening" cause, hastening the advent of symptoms which would otherwise have appeared at a later date. On this subject we cannot, of course, speak positively.

NOTE.—This case continued to improve under the iodide of potassium, until finally she had recovered the entire use of the right side of the body. This was after she had been in the hospital six weeks. The left side regained some power. The contracture of the hand had existed so long that it appeared to be irremediable.

---

#### CLINICAL CERTAINTIES.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

IN the March number of this journal, Dr. W. S. Searles, of Brooklyn, N. Y., initiated a department of so-called clinical certainties; and as no one has yet heard his call for mutual interchange of favorite therapeutic and diagnostic stepping-stones to clinical success, I send a few fragmentary therapeutic curiosities on which I feel that I may rely in moments of trial. Such a department as the doctor proposes appeals to one who is looking and watching for certainties in medicine—things, unfortunately, not frequent in the changing kaleidoscope of sick humanity, with its varying and various combinations.

*Croup.*—*Veratrum viride* I also have found very useful in croup, as Dr. Searles has done, but it was the catarrhal variety, and not the true membranous form. It may seem unnecessary to our scientific brethren to make such a statement, for they look on all membranous croup cases as diphtheritic. That is a serious question, in my mind, on account of the attending features of isolation and contagiousness, if it be diphtheritic. I had recently a very severe case of membranous croup, which recovered under  $\frac{1}{3}$ -drop doses of the tincture of iodine every

half-hour and intubation. The intubation was of minor importance, as the tube was coughed out after a few hours, and, indeed, it gave more distress than aid. That there was a distinct, tough, pearly-white membrane was evidenced by two large strips detached by the tube, which was inserted after three difficult attempts. Kali bich. 2x is another faithful croup remedy, indicated in the membranous as well as in the catarrhal variety. The iodide of lime is still another for the catarrhal form.

*Purpuric Hæmorrhages.*—I never have used the snake-poisons as anti-purpuric remedies, but in a recent case of purpura, with large reddish blotches dispersed over the whole body, with urticarial wheals on the arms and hands, chiefly, I found that the iodide of potash, in doses of a third of a grain, every two hours, cleared up the whole eruption in a day and a half.

*Biliousness.*—I have always had a distrust of this term, on account of so many physicians huddling all sorts of states due to non-elimination and auto-intoxication under this word. Whenever I have so-called bilious cases I invariably examine the urine for *albumin* and specific gravity, to see if an uræmic attack is not coming on. There is a great deal of nephritis stalking about unrecognized; in fact, so much as to make one chary of nearly every one who is anæmic, nervous, dyspeptic or bilious.

As to urinary tests, the best practical one I have found, after using a number of all varieties, both delicate and coarse, is simple boiling of the upper portion of half a test-tube of acidulated urine. This will reveal albumin with certainty when the nitric-acid test will not, and also when the finer and more delicate tests, as Spiegler's, Jolles' and Touret's do, yet to such an extent as to make one doubt whether the albumin is present in quantity sufficient to be pathological.

If albumin shows with the cold nitric-acid test, then it is *decidedly present in pathological quantities*.

*Offensive Secretions.*—"The worse that a patient smell, the worse that he is." There is a great deal of truth in this. I have more than once been set upon the right track, in obscure chronic diseases, by smelling a musty, cadaverous and ammoniacal sweat in patients with chronic diffuse nephritis, or possibly in some of the other varieties of Bright's disease. That



musty, dead-smelling odor of the perspiration means trouble in the kidneys, in my experience. The stools of such patients will also give out a terribly offensive odor, with a greasy, dirty appearance, like that of melted home-made taffy candy.

*Colocynth in Colics.*—I must confess that I never have had any success with colocynthis in colics. Nux vom. has served me well. Dioscorea vill., in the tincture or lower attenuations, I have found an unfailing drug in gastrodynia, in the region above the navel—an eclectic indication; in fact, it is one of my best remedies in this condition; one that I can generally swear by, give, and go away, and know that when I return it has acted.

*Chloroform to Abort a Malarial Chill.*—I know of a physician in a neighboring community who attempted to abort a malarial chill in a woman with a teaspoonful-dose of chloroform. It succeeded, but it set up such a commotion in her “innards” that he never heard the last thereof. This might be a companion “cure” of that reported recently for breaking up a hysterical attack. Take a drachm, each, of tincture of lobelia, capsicum and assafœtida. Inject, during the attack, into the woman’s rectum. Immediately afterwards leave the house. *Do not neglect that.* That woman will think only of two things in a few moments—that doctor and her rectum. It is a howling success.

*Gastric Catarrh and Ulcer.*—In these states my mainstay is the nitrate of silver in the first three dilutions, dispensed in a dark bottle, in *vitro fusco*, as the old German pharmacopœias say. Frequent ineffectual belching should not only lead the physician to examine the heart, but the *urine* as well. It may be a symptom of chronic Bright’s disease. The same holds true of a chronic cough; profuse and non-relieving sweating; also a sign of opium-eating; chronic, ill-defined rheumatic pains, in the legs particularly. A feeling of persistent tiredness in persons of middle age is a suspicious sign, and should send one sniffing around diagnostically. A chronic diarrhœa, or alternate periods of constipation and diarrhœa, will bear watching. But, above all, a full, heavy, high-tension pulse is indicative of coming trouble, possibly in the distant future; yet it is quite certainly booked. When such a patient, after running down *with any kind of symptoms*, or set or complex of

symptoms, and, on examination, you find his urine distinctly albuminous, perhaps after having found it free from it during repeated examinations, then you might as well hang up your fiddle. Such a patient will almost certainly die, and in a short time. He has been suffering from chronic interstitial nephritis, his kidneys are giving way, they have become congested, and the old and worn-out machine can work no longer. As uræmia creeps onto him, perhaps cantharis  $\epsilon$ , in drop doses, will push off the inevitable for a time. It did it for me in one case.

*Senega in Bronchitis of Old People.*—I have found senega, either in the tincture or fluid extract, five drops to four ounces of water, a faithful remedy which has never failed me in the asthenic bronchitis of old people, with chronic interstitial nephritis, or with chronic emphysema, where it acts best, and in old asthmatics with congestive attacks. Too big a dose will purge such patients and weaken them, in some instances. *In medias res* is safety. But if the great sluices, the kidneys, are congested, and the bronchitis is an accompanying symptom of the terminal stages of Bright's disease, then it will help, but not so brilliantly.

*The Stomach in Heart Diseases.*—I have found from painful experience that the heart is a queer organ, and very frequently acts best if not treated too much, but better if the obstructions in other organs—in the stomach, intestines, liver and kidneys—are, so to speak, lifted from the track.

Of all things, a dyspepsia associated with heart disease should be treated first, and with attention, particularly if there be either gastric or intestinal flatulency. In such, digitalis will only aggravate and throw the patient into the shadows. No one has tried harder than the great and sensible Huchard, of Paris, to impress this fact upon the medical mind. Probably no one is better able to judge than he.

As to heart tonics, in my humble opinion there are none better than the iodide of potash, strychnine, arsenic, digitalis and the bromide of potash, the latter particularly in functional cardiac affections.

*Phytolacca in Enlarged Cervical and Submaxillary Glands.*—Every one meets with tonsillitis, sore throats of various kinds and degrees, after which a cervical gland or a conglomerate of glands remains painfully enlarged at the angle of the jaw.

If one try the ordinary remedies, he will give iodium, the mercurial preparations, or possibly follow Teste, and give rhus in a vertiginous attenuation, and fail; then, after fussing around with a few more drugs, consult an old-school text-book, and daub on some tincture of iodine, and—fail again. Such little things bother one, and lead patients away. I have found the tincture of phytolacca, in doses of a tenth to a fifth of a drop every two or three hours, the veritable specific in these cases. These glands will dissolve away and everybody be satisfied. That is an eclectic indication that is worth remembering.

*Lugol's Solution in Oozing Wounds, in Cavities that are not Septic, yet Refuse to Heal.*—If in this condition, the iodine preparation known as Lugol's solution, dropped into a washdishful of water until the water takes on the color of cider, and this solution thus prepared be used as an injection, one will be surprised with what rapidity oozing wounds or wound-cavities that keep clean enough and still are not septic, yet ooze, bleed and ooze, and yet refuse to heal, will dry up and heal under a few irrigations of this liquid.

*A Local Application for Ringworm.*—I have found a topical application of a mixture of iodine in tincture with oil of turpentine, 1 : 10, an excellent measure of curing this parasitic affection. Many text-books on dermatology recommend a mixture of corrosive sublimate, suspended or dissolved in compound tincture of benzoin. In ringworm, with suppuration of the hair-follicles, this is a disappointing application. The turpentine and iodine mixture will do better.

*White Precipitate in Impetigo Contagiosa.*—A salve of white precipitate, from ten grains to a drachm to the ounce of vaseline or benzoated lard, applied once or twice a day, will soon dry up the persistent pustules. Any other treatment will be a miserable failure. I have to thank Dr. Gramm, of Philadelphia, for this therapeutic suggestion, which has been of great service to me.

*A Long-Felt Want.*—I wish that some one would publish a formula for a good antiseptic, deodorant and detergent solution for use in cases of nasal catarrh. I have been looking for years for one. I am yet looking.



## PERTUSSIS AND PAROTIDITIS: THEIR TREATMENT.

BY GEORGE B. PECK, M.D., PROVIDENCE, R. I.

(Read before the American Institute of Homœopathy at Omaha, Neb.)

OUT of every thousand prescriptions by members of this Society for the amelioration of that group of morbid phenomena popularly designated whooping-cough, at least 175 are for *drosera*, 153 for *belladonna*, 123 for *ipecacuanha*, 76 for *cuprum* (metallicum or aceticum), 54 for *corralium rubrum*, 44 for *antimonium et potassium tartaricum*, 24 for *mepitis*, 20 each for *aconitum napellus* and for *hyoseyamus*, 18 for *naphthalin*, 15 for *coccus cacti*, 13 for *kali bichromicum*, 11 for *bryonia*, 9 for *magnesia phosphorica*, 8 for *chelidonium majus*, 6 each for *ammonium bromidium* and *castanea vesca*, 5 each for *arsenicum album*, *bromoform* and *hepar sulphuris calcareum*; 4 each for *ambrosia artemesifolia*, *carbo vegetabilis*, *calcareo carbonica*, *calcareo phosphorica*, *cina*, *gelsemium* and *hydrocyanic acid*; 2 each for *bromium*, *iodium*, *kali bromatum*, *kali carbonicum*, *kali muriaticum*, *lobelia inflata*, *magnesia phosphorica*, *mercurius solubilis*, *mercurius vivus*, *passiflora incarnata*, *phosphorus*, *sambucus*, *veratrum album* and *veratrum viride*; 1 each for *antipyrin*, *arnica*, *asafoetida*, *camphor monobromide*, *capsicum*, *carduus benedictus*, *chamomilla*, *cimicifuga*, *cnicus arvensis*, *conium*, *cuprum ammonio sulphuricum*, *ferrum phosphoricum*, *grindelia robusta*, *lactuca*, *opium*, *petroleum*, *phenacetine*, *phenocoli*, *pulsatilla*, *rumex crispus*, *spongia*, *thymus*, *bromide of gold* and *extract of chestnut leaves*. One doctor mixes in solution the bichromate of potassium with the iodide and nitrate, and administers a dose every half-hour or every three hours as the condition indicates; another gives no medicine, but depends on *cresoline*; a third has discovered that "no remedy is especially adapted;" a fourth finds the indicated remedy is sufficient, the only trouble is to find it; a fifth failed to report the medicaments administered; while a sixth, who has practiced seven years, has never met with a case of *pertussis*, but quite a number of cases of *mumps*, all in persons over twenty years of age, and most of them in women.

No special accessory measures are resorted to by 63 of my 200 correspondents, although 46 recommended open air without exposure. Cresoline vapor is resorted to by 20, one remarking that it is more valuable than all other medication, and another that creasote may be substituted, while the cresoline lamp is specified by 7 others. Changes of temperature are avoided by 15, which protection 2 others secure by keeping their patients in the house, as many restrict them to a warm room, and 3 to rooms with a warm, moist temperature. Six direct to keep the sick warm, at least 2 of whom intimate plainly that it is to be accomplished through suitable clothing. Five send them to a gas-house, while as many more are content with steam inhalations. Four order oil rubbings, 3 sulphur to be burned in the room, and as many more a sail on salt water. An equal number find the spasm often relieved by drawing forward the lower jaw during an attack. Resorcine spray, carbolic acid vapors, eucalyptus fumes, formaldehyde fumes, Roche's embrocation, slippery-elm tea with lemon and sugar, plenty of drinking-water, warm or cold, protection of the chest, flannel to the skin, in severe cases change of climate are recommended each by 2. Single practitioners recommend change of air, change of location, sending to lower elevation, the avoidance of dust and odors and excessive exercise, keeping the patient as quiet as possible, rest in bed, bath during fever, hot fomentations, cold-water compresses, pinus ointment, turpentine and lard, stimulating embrocations, warm cocoanut to chest on flannel, rum and garlic locally, glycerine externally, flannel to back and chest saturated with a mixture of camphorated oil,  $\mathfrak{3ij}$ ; vaseline,  $\mathfrak{3ij}$ ; terebinth.,  $\mathfrak{3j}$ , and in bad or complicated cases the bowels and liver to be kept active; tar ointment, inunctions of cocoanut oil, inunctions of vaseline, inunctions of lanolin, hot-lard rubbing, salt glow, cold bath every morning, warm baths, sea-water baths, chamois chest-protector, cotton or wool jacket, normal woolen stuff, snug-fitting jacket for support to chest, turpentine fumes, sulphur fumes, formalin 2 per cent. spray in room, peroxide of hydrogen vaporized, coal-tar vapors, medicated vapors, steam, terebine inhalations, dilute amyl nitrite inhalations, chloroform inhalations, antiseptic vapors (like menthol, cresoline, etc.), sponge containing a few drops of the oil of eucalyptus suspended over the sleeper,

a sponge tied on the chest below the chin and saturated with a mixture of the oils of turpentine and eucalyptus, aa. ʒss, in alcohol sufficient to make one pint, lemonade, flaxseed tea with lemon and syrup, sugar, occasional small doses of chloral, castanea vesca syrup, ten drops of glycerin in the throat, hot compresses to the throat, occasional hot hamamelis fomentations to the throat, compression of the throat hot or cold, protection from excitement, restraining of the cough if possible by swallowing, an abdominal bandage in severe cases, an abundance of fresh air but not too cold an atmosphere, keeping the patient in a warm moist atmosphere and various inhalations occasionally. One states that three fumigations will cure the neuroses; two forbid all inhalations, and another all disinfecting lotions, as well as all things else that pollute the air; a fifth keeps his patient in the open air as much as possible after the catarrhal stage has been controlled, while a sixth orders his change of air in the later stages of the disorder. One doctor keeps his patients seated and quiet, always in an upright position when coughing, holding little ones thus; another tickles the throat with a feather if suffocation threatens during a very violent paroxysm; still another has found the cresoline lamp a failure, while yet another recommends "*moderation in everything.*" Three doctors at once vaccinate if the patient has not been already thus treated, having observed the cough often subsides as the resulting inflammation manifests itself. Seven correspondents make no statement on this topic.

No change at all is made in the dietary of sufferers from pertussis by 51 per cent. of our members. A light, easily-digested (nutritious) diet is recommended by 13 per cent.; good, nourishing food by 7 per cent., one of whom specifies malt preparations; an easily-digested diet by 6 per cent.; a liquid diet by 4 per cent.; a semi-solid diet and a milk diet, each by 1 per cent. More frequent feeding, with smaller quantities, is recommended by 6 per cent. Three doctors permit the ordinary diet for two meals each day, but for the third two order a light diet, while the other specifies milk and broth. One orders, when the patient is very sick, a light diet; another says "Feed well;" a third cautions "Eat slow;" a fourth urges an abundance of simple and nourishing foods; a fifth believes in bovine; a sixth gives children crust coffee, and older pa-



tients corn-meal gruel always; a seventh directs, in general, easily-digested and nourishing food, while an eighth permits a tonic diet in lingering cases only, while in acute cases the diet is antifebrile. On the other hand, five forbid coffee and four tea, while single individuals prohibit sweets, acids, condensed sweets, highly-seasoned food, sour food, salted food, pepper, vinegar and very salted meat. One says, "Don't overload the stomach," another warns against indigestible food, a third permits the use of all cereals except oatmeal, while a fourth desires the diet should be nourishing, but unirritating. Another avoids nitrogenous food in general, while two others "avoid too much meat," and a fourth tersely directs less meat. One makes no change unless the vomiting is excessive, and then he gives solid food. Four only failed to testify on this subject.

Of every thousand prescriptions for the relief of that unique inflammation of the salivary glands known as mumps, at least 143 are for belladonna, 100 for pulsatilla, 81 for mercurius vivus, 64 for mercurius solubilis, 51 for rhus tox., 50 for aconitum napellus, 39 for phytolacca, 36 for mercurius iodatus ruber, 19 for mercurius iodatus flavus, 15 for mercurius iodatus unspecified, 13 for kali muriaticum, 9 each for bryonia and mercurius corrosivus, 8 for gelsemium, 6 each for apis and iodium, 5 each for calcarea carbonica, ferrum phosphoricum and hepar sulphuris calcareum, 4 each for arsenicum album, baryta carbonica or acetica, conium and lachesis, 3 each for arsenicum iodatum, calcarea fluorata, carbo vegetabilis, clematis and silicea, 1 each for aurum, aurum muriaticum, baryta muriatica, bromium, colchicum, euphrasia, hamamelis, jaborandi, kali bichromicum, kali iodatum, lycopodium, mercurius dulcis, natrum iodatum, nitricum acidum, oxalicum acidum, staphisagria, sulphur and veratrum (unspecified). Three correspondents passed this topic; as many stated they have no special remedy, but treat the symptoms as they arise; one administers the indicated antipsoric, another seldom uses remedies, while a third never treats mumps, averring that nature does better than he can.

Accessory treatment is not resorted to for the relief of mumps by 51 of my correspondents, while 16 others do not declare their habit. Thirteen avoid changes of temperature, and 17 vaguely apply heat to the glands. Fifteen resort to

cotton batting or cotton flannel or absorbent cotton, one insisting that the application be hot; 12 employ hot fomentations, and 6 dry heat; 5 apply phytolacca cerate or ointment, 4 belladonna ointment, 3 camphorated oil, as many hot poultices occasionally; 2 cold water, hamamelis, hot oil, flaxseed poultices, plain bandage, unspecified inunctions, a weak iodine solution; 1 each a lard or vaseline and nutmeg poultice on flannel, lard and camphor, a compress saturated with one quart of hot water containing sweet-oil  $\mathfrak{z}\text{ij}$  and spirits of ammonia  $\mathfrak{z}\text{j}$ , a compress saturated with equal parts of alcohol and water, the cerate of the indicated remedy, bacon-rind around the neck, cool compresses (which may be the temperature of the body, if desired), local applications sometimes, hot poultices, hot cosmoline, hot sweet-oil, hot hamamelis, hot lard, mixture of equal parts of calendula and glycerin, unguentum camphorphenique, bean poultice, salt bacon, lanolin containing 5 per cent. of iodine, vaseline, hop poultices, hot water and hamamelis, belladonna plaster, aconite lotion, belladonna lotion, mixture of belladonna  $\mathfrak{z}\text{j}$ , glycerin  $\mathfrak{z}\text{j}$ , rubbed on the glands. Three cover the swollen parts of the face tightly to keep the air away; 1 ties a soft silk handkerchief over the ears, while another orders covering only when the air is uncomfortable. Thirteen are careful that their patients are warm, while 7 order rest, which 11 make sure of by keeping them in bed. Three doctors simply desire them to be quiet, one wishes them to avoid draughts and overheated rooms, another desires for them fresh air, but the next seeks the avoidance of air. Nine confine their patients to the house, but two simply order them to avoid taking cold, which another secures by the use of warm wraps.

Metastasis of mumps to the breasts is not a common occurrence. Not a single instance has been observed by 156 physicians in 3020 years in their own practice, nor by 175 doctors in 3376 years in their consultation practice. On the contrary, in private practice 2 have seen 10 each in a total of 25 years; 2, 6 each in 77 years; 1, 5 in 46 years; 3, 3 each in 80 years; 6, 2 each in 147 years; and 11, 1 each in 274 years. In consultation, 1 has seen 10 in 9 years; another, 6 in 15; a third, 4 in 45 years; 2, 3 each in 63 years; 3, 2 each in 101 years; and 1, 1 only in 20 years. Besides, 13 report treating, each, several cases in 359 years, and four, many in 88 years, while,

in consultation, 12 in 321 years and 1 in 35 years give corresponding answers. Omitting these, on account of their indefiniteness, and summarizing, we find that 181 practitioners have noted in their own practice but 69 cases in 3669 years; and 184 but 33 in 3629 years in consultation, or one case has been met every 53 years and consulted upon every 109 years. Generalizing now, by allowing liberally for the indefinite replies, it is safe to affirm that a decent homœopathist need not expect to meet a case of metastasis to the breast oftener than once in fifty years, or be called in consultation by a brother homœopathist once in a century—though that *once may* be to-morrow!

For the relief of this condition pulsatilla was prescribed at least twenty-five times, phytolacca nine, aconite and bryonia each five, belladonna and conium each three, hepar sulphuris calcareum and sulphur each two, apis mellifica, arnica, arsenicum album, calcarea carbonica, calcarea iodata, clematis, gelsemium, kali muriaticum, mercurius solubilis, mercurius vivus, rhododendron, rhus toxicodendron, thuja, veratrum and “the indicated remedy” one. Three doctors confined their patients to the bed, and as many applied belladonna ointment; two applied cotton and a tight bandage, and an equal number hot applications of hamamelis. Single physicians order the hot-water bottle locally, the indicated remedy locally, bandaging, the prone position, even temperature, the parotid region warmly protected, warm fomentations, hot dry fomentations, phytolacca poultice, flaxseed poultice, lukewarm cataplasm, fresh lard, hot applications, veratrum viride cerate to breasts, a mixture of phytolacca and water, one to four, hot or cold, as agreeable, and “in one case only antiphlogistine externally.” One practitioner kept the breasts warm, another provided even temperature, a third allowed but little light for fear of the eyes, while a fourth used a hot-water bottle in an unspecified locality.

The metastasis of mumps to the testicles is of comparatively frequent occurrence despite the fact that 52 gentlemen have practiced 973 years without meeting a case, and 137 practiced 2602 years without seeing one in consultation. On the other hand, 1 practitioner has treated 25 in 40 years, another 20 in 10 years, 5 each 12 in 125, 4 each 10 in 87, 3 each 9 in 79, 4 each 7 in 72, 8 each 6 in 195, 5 each 5 in 92, 2 each 4 in 43, 16 each 3 in 253, 19 each 2 in 364, and 31 1 each in 603.



Moreover, in consultation 1 practitioner has seen 9 cases in 15 years, another 8 in 46, 2 each 6 in 37, 4 each 4 in 91, as many 3 each in 102, 13 each 2 in 273, and 7 each 1 in 180. Combining, we find 151 doctors have treated 398 cases in 2936 years, or 1 in about every 7 years 5 months, and 169 have consulted on 90 cases in 3346, or 1 in every 37 years 2 months. But in addition 23 have treated "quite a number" in 594 years, and as many "some" in 542, while 19 have consulted concerning "quite a number" in 364 years, and as many "some" in 473 years. Generalizing, we may expect to treat a case of orchitis following mumps once in six years, and be consulted in relation thereto once in thirty-five years.

For the relief of the above-mentioned cases of metastasis of mumps to the testicles pulsatilla has been prescribed by 99 physicians, belladonna by 40, clematis by 20, aconite by 13, phytolacca by 9, mercurius solubilis and vivus each 8, bryonia and gelsemium each 7, conium by 6, arsenicum by 5, mercurius iodatus (unspecified) by 4, mercurius biniodatus, mercurius corrosivus, rhododendron and thuja each by 3; apis calcarea carbonica, carbo vegetabilis, hamamelis, kali muriaticum, rhus toxicodendron, sulphur and veratrum viride each by 2; antimonium crudum, arnica, baptisia, calcarea phosphorica, ipecacuanha, kali iodatum, lycopodium, mercurius protiodatus, "the mercurials," staphisagria, antimonium et potassium tartaricum, veratrum (undesigned) and a dose of Epsom salts each by one. Furthermore, 39 resort to suspension, 21 to warm fomentations, 18 to rest in bed, 17 to the application of hot water and hamamelis extract, 10 to hamamelis, 9 to rest, 7 to hot applications in general, 6 to belladonna ointment or cerate, 5 to tobacco poultices, and as many to warm poultices (material unspecified); 4 each to dry heat, a recumbent position and bean poultices; 3 each to hot poultices (to which, if the pain is very severe, 1 adds tobacco and the tincture of opium), boiled bean poultices and a light diet; 2 each to warm hamamelis, iodine, cool compresses and flaxseed poultices; 1 each to white bean poultices medicated with the bicarbonate of soda, hot bran poultices, hot lotions, hot cosmoline, a vaseline dressing, a nitrate of silver solution, rest on the back, belladonna and glycerine locally, sometimes cold applications, a paste of the subnitrate of bismuth and hamamelis, hamamelis or the sub-

nitrate of bismuth, arnica and other soothing lotions, moist heat, phytolacca cerate, phytolacca poultice, phytolacca solution, strapping, cooling lotions, belladonna fomentations, calendula solution, alcohol, a solution of five grains of chloral hydrate in an ounce of hot water, subnitrate of bismuth paste, hot-water bag to testicles, hot poultices, hot water and arnica, guaiacol locally, ichthyol and water, local applications unspecified. One ordered cereal foods, but another *dieting*. One pencilled with carbolic acid over the part, another saw that the parotid region was warmly protected, and a third, when orchitis occurred, applied warm fomentations of hamamelis. One affirms that hot applications are of no good, while another states a patient informed him that it was customary in that region to tie a tarred rope tightly around the waist to prevent the mumps going down, which procedure proved successful.

Concerning the complications of pertussis, at least 12 doctors report they never witnessed any, 2 but seldom, and 2 don't allow such things to occur. Three others state that after the use of the indicated remedy little trouble was experienced. One treats the disease as a neurosis and prescribes accordingly. Another considers safety is to be found in exact prescribing rather than in haphazard medication and authoritative routine. On the supervention of ophthalmic trouble 2 send for the appropriate specialist, others darken the room and administer euphrasia, aconite, apis, belladonna, pulsatilla, gelsemium or hepar internally; hamamelis or listerine in hot water or boracic acid, collyrium externally, or arnica, calendula or hamamelis either way. It is affirmed that gastric disturbance is a part of the disease and not a complication. Its existence suggests reduction in the amount of food taken at one time, but over a dozen refer to the importance of its frequent administration even to immediately after the paroxysm. Liquid diet is recommended by a considerable number of the practitioners. At least it should be unstimulating and easily assimilable. Hot applications over the stomach or any other convenient application of counter-irritation may prove most advantageous by hastening the digestion of food. Cold liquid foods are sometimes useful. Ten grains of the oxalate of cerium with antimonium crudum, arsenicum, carbo veg., ipecacuanha and tabacum, as well as fresh fruit juices, may be thought of at this point.

Broncho-pneumonia is most dreaded. Ipecacuanha, phosphorus, tartar emetic, veratrum viride, antimonium arsenicum are to be thought of in this connection. Brain difficulties are apt to require apis, belladonna, bryonia and hellebore. It is much easier to prescribe for complicated cases than others. Vomiting is believed to be somewhat salutary, moderating the severity of the disorder. One gentleman has found most physicians have not confidence in vaccination as a cure for whooping-cough and do not resort to it. Symptoms relieved in two or three days are not ordinarily cured until the end of twenty-four or twenty-eight days. One correspondent had suffered from the disease himself at five years and twenty-five, and had seen two others similarly afflicted. Ipecac should be thought of when there is hæmorrhage from the nose or chest. A child's death from diabetes succeeding pertussis is mentioned.

Concerning the treatment of parotiditis, it is further suggested by 27 that the diet be light (and nourishing), by 22 fluid (but nourishing), by 3 semi-liquid, by 2 each bland and milk, while one demands absolute rest from food. Another simply restricts the diet, which yet another limits strictly to corn or oatmeal. On the contrary, one believes in a plenty of good wholesome food, while yet another orders milk diet only in the case of gastric disturbance. Two physicians forbid cold drinks, and one each vinegar and pickles, fats and oils, salty articles and stimulating foods and drinks. Seven direct the avoidance of acids and acid fruits except when the patient calls for them. Two direct that the bowels be kept open, and single individuals each a plenty of water and cooling drinks. Six tell their patients to keep warm and five to avoid exposure; three to rest, three others to rest indoors, and yet three others to rest in bed. One wishes to secure bodily quietness, but another permits exercise in one's room. One orders warmed *fresh* air, another dry warmth, and yet another an even temperature in the room. Where there is both gastric and hepatic troubles iris versicolor is suggested, and for the typhoid form gelsemium and rhus toxicodendron. An involuntary diarrhœa, frequently provoked, is often controlled by mercurius solubilis. One physician recommends the application of an ice-bag to the glands, another cautions against going out too soon, a third insists upon prolonged rest in convalescence, while a fourth directs the avoidance of



reading at that time. One doctor provides easily-managed food for obvious reasons. An instance is mentioned where pneumonia supervened upon mumps, exhibiting phenomena identical with other metastatic cases. Mercurius had no effect on the previous disorder, but the latter indicated *carbo vegetabilis*, which promptly cured both. A number of cases of metastasis to the brain are reported, in some of which *hyoscyamus* and *belladonna* were effective. An attack of one-sided mumps accompanied by severe vertigo and semi-coma, lasting two weeks, was apparently cured by zinc phosphide 2x. In reply to an inquiry, I will state I know no reason why an attack of this disorder on one side of the face should prevent a similar manifestation on the other at a later period. Neither of the disorders considered in this paper are prevalent in North Dakota, though more cases of the former are found than of the latter.

---

### THE TREATMENT OF HÆMORRHOIDS.

BY F. WALTER BRIERLY, M.S., M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia, March 10, 1898.)

THE question is often asked of me, "How do you treat hæmorrhoids at Hahnemann?" and I am forced to reply that I do not know. No two cases are treated alike. One learns to treat piles as he learns to put on bandages; typical methods are studied, then they are modified and combined to suit the individual case. Of all places, hard and fast rules have no place in rectal surgery, and individual judgment counts for more than text-book knowledge.

In their incipiency most cases of hæmorrhoids are amenable to medical and hygienic treatment. In recent cases, and before they have become inflamed, they are simply distended veins. It is in this stage only that medicine will cure, though under other conditions medicine will do much by way of palliation. In selecting a remedy the cause of the attack must be kept well in mind. The hæmorrhoidal veins belonging to the rectum proper pass all their blood through the liver before it reaches the heart, hence anything that interferes with the portal

circulation tends to cause hæmorrhoids. A crippled heart is often found to be the cause of these varicocities. To go into the therapeutics of the heart and liver is out of the question to-night. Internal medication in the treatment of hæmorrhoids is important, and sometimes very gratifying, but a full knowledge of the condition present is absolutely necessary to a proper prescription. The greatest mistake that can be made in the beginning of treatment is to make no examination of the parts affected.

With the wall of the vein thickened by long-continued irritation or by inflammation, and perhaps with enormously dilated pouches and organized blood-clots, medicine, except to remove the cause or to prevent recurrence, is useless, and the case becomes essentially surgical.

When it is once decided that a case is beyond medical treatment the question arises, "Can this patient be treated by one of the ambulant methods, or must he have a general anæsthetic and a radical operation?" This will depend not only on the condition of the rectum, but on the circumstances and caprice of the patient. Even in cases where operation is clearly indicated, much may be accomplished as regards temporary comfort by the strict hygienic measures enforced on our patients who are under medical treatment. Alcohol must be used sparingly or not at all, and all food which tends to congest the liver must be avoided. Regular exercise is beneficial, and there must be no constipation. An acute attack of hæmorrhoidal congestion is almost always brought on by constipation. The application of hot or cold water, as is agreeable to the patient, often gives great relief.

The hæmorrhoids of pregnancy usually disappear after delivery; should this not be the case, their treatment is the same as those having any other cause. Those from enlarged prostate are obstinate because the treatment of their cause is unsatisfactory. As few patients present themselves at the beginning of their trouble, most cases have reached the surgical stage before we see them, though many may still receive ambulant treatment. The cure of those piles that lie in the skin outside the anus is usually simple and easy. Old skin tags should be trimmed away, care being taken not to make a cut that will lie within the grasp of the sphincter. External venous piles, in-

flamed or not, should be incised and packed. The injection of cocaine or eucaine produces sufficient anæsthesia for these operations. The treatment of internal piles is not so easy. It is well to start with dilatation of the sphincter, and this, in mild cases, may be all that is necessary to effect a cure. The sphincter should be paralyzed, and under such an anæsthetic as nitrous oxide or ether administered by the Grigsby method. Small tumors may be painted every third or fourth day with a 4 per cent. solution of silver nitrate, and will sometimes rapidly disappear under this treatment. Those somewhat larger may be injected with some substance which will cause the formation of a clot, and the tumors, one or two at a time, obliterated in this manner. A still better method is the injection around the vein, and not into it, of some sclerogenic substance as a 10 per cent. solution of iodoform in ether or of zinc chloride in water. The tumors should be brushed with a 10 per cent. solution of eucaine or a 4 per cent. solution of cocaine before the injections are made. The contraction of the scar tissue soon obliterates the lumen of the vessel. The injection treatment of hæmorrhoids is not without danger, and deaths have occurred from the formation of emboli.

A patient once etherized, there is a fair field for choice of operations. A number of these depend principally for their results on the well-known contractile power of scar tissue, and particularly the scar tissue that follows a burn. Puncture of the pile with a hot iron has long been the custom of some eastern nations, and has been advocated by a few English surgeons. Linear cauterization has been another favorite method. The Paquelin cautery has made all of these operations comparatively easy, and the cautery applied after clamping the pile at its base is, in most hands, the most satisfactory treatment at the present time. The old method of ligating hæmorrhoids gives good results, but is exceedingly painful. It is advocated by Allingham, and is still much used in England. Pratt says one might as well amputate a leg by putting on a ligature and waiting for the leg to slough off.

These methods of operating have long been recognized as unsurgical, and the attempt was made to get away from them by the Whitehead and American operations; but the results of removing the nerve-endings from the lower inch of the



bowel, to say nothing of the sphincter, as has been done by unskilled hands, were far from encouraging, and the reaction was followed by a general return to older methods. To-day, however, hæmorrhoids are being treated more and more by sound surgical methods. Hæmorrhage is not feared in rectal operations as it once was, and paralysis of the sphincter prevents the treacherous retention of blood in the rectum. More and more it is being recognized that scar tissue is undesirable if not dangerous tissue; more and more are we realizing that nerves must not be pinched by ligature or cicatrix. The pile may be split open, bleeding vessels secured, and the tumor allowed to collapse. An incision may be made the length of the tumor through the mucous membrane, the wall of the vessel grasped with forceps, and the pedicle of the pile ligated and the tumor removed. In large hæmorrhoids, Marcey makes a dissection as in the Whitehead operation, except that he takes up the mucous membrane only; then the tumors are each ligated and cut away, and the mucous membrane anchored to the skin in its original position. These methods, with some modifications, are being practiced by nearly every man who does much rectal surgery, but, as I have said before, for the man with ordinary skill in rectal work the clamp and cautery operation offers the most advantages.

The pain after rectal operations is well controlled by a suppository of opium, one grain, and extract of belladonna, one-fourth of a grain. On the third day, as a rule, the bowels should be opened by a brisk saline cathartic. I hardly need say in this day that surgical cleanliness is necessary to good results, and that union by first intention may be obtained even in the rectum.

---

ALUMINA, when there is a relaxed condition of the mucous membranes; it is just the condition you meet with in clergyman's sore throat. The throat is dark red, the uvula elongated. Hoarseness appears worse in the morning, with a feeling as of a splinter in the throat when swallowing.

Sanguinaria is marked by the extreme dryness of the mucous surfaces. The nose becomes sore and raw, with a fluent and irritating coryza. There is aphonia, and in the throat a feeling of swelling that seems as if it would choke him.—*The Homœopathic Eye, Ear and Throat Journal*, August, 1898.

## EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

## PROBABILITIES.

To the homœopaths of the last generation the endeavor to discover the *genus epidemicus* was one of the most interesting and helpful problems of their daily practice. Here in America, but still more in Germany, neighboring physicians were in the habit of forming themselves into clubs or circles, for the purpose of exchanging experiences, whereby they might arrive at a knowledge of the prevailing type of disease, and, what concerned them then much more, the indicated remedy. It is no doubt to these "collective investigations," prosecuted from an entirely practical standpoint, that we owe many of the most reliable clinical indications for the use of our remedies.

At the present time we seldom hear of such attempt at useful generalizations. Perhaps it is because the simple practical methods of pure observation employed by those pioneers are not sufficiently abstruse and recondite to satisfy the demands of this scientific age. But with our daily weather reports, and our weekly mortality lists, a basis could surely be given to our observations quite scientific enough to satisfy the demands of the most exacting.

The coming year promises to be a most propitious time for undertaking such collective investigations, and we hope to see evidences in the papers presented at the various State and County societies and in the journals, that others have shared this view with us.

We have two causes of disease acting throughout our whole country with considerable uniformity, and it would be strange if a comparison of the results of their activity could not be made to assist greatly in the development of medical science and of our own system of therapeutics. The causes we refer to are, the effects of the widespread prevalence of unusually long-continued periods of intense heat and great humidity during the

past summer, and, the certain spreading of disease through the return to their homes of half-cured soldiers.

We are not usually alarmists, in fact we are generally the very opposite, but we cannot help viewing with apprehension the very probable consequences of the action to which the Government has been driven by the wave of hysterical sentimentality which is sweeping over the land.

We know how much credence to give to the fervid details of provident penny-a-liners who delight to harrow the feelings of their readers with glowing word-pictures of the poor soldiers, thrust out as convalescents from the hospitals, dragging their emaciated frames through the heartless streets to the cars which are to take them home. We all know how this supposed fact has been, and is, time and again, dished up in the various newspapers, with a wealth of adjective and imagination which must soon pall upon the taste. But making all due allowance for the enterprise of the reporter, who would not be true to his calling were he not to work this Klondike of war news for all it is worth as long as it lasts, the fact remains that the Government, or rather the hospitals under government control, have in many cases allowed to return to their homes, or perhaps even sent back to their clamoring relatives, invalided soldiers whose condition demanded their retention, not only for their own good, but also for the good of their native community and of the country at large. Theoretical science as well as practical experience have shown that in the case of typhoid fever the danger of spreading the disease is not past as soon as the patient becomes convalescent. The germs of the disease may still be present in him, and, while they may not exist in sufficient numbers or virulence to prevent his own recovery, they may still be capable of originating the disease in others. By the distribution of the soldiers to their respective homes in all parts of the country, in the first stage of convalescence, or perhaps exhibiting only the undefined prodromal symptoms of an attack of typhoid fever, we are virtually scattering broadcast possible seeds of disease, and multiplying almost indefinitely probable foci of epidemics.

It is a dangerous experiment but one to which we think the Government has in a measure been forced by circumstances. Its own want of proper hospital facilities and healthy detention-



camp, the unthinking and often unjust criticism of unavoidable conditions, together with the wailing of tender-hearted people who have either never known or have forgotten what distress war brings in its train, have driven the authorities to seek to rid themselves of the responsibility of caring for the invalids as soon as, or even before, they are really able to travel to their homes.

We are of the opinion that much of the sickness experienced in the army, and which seems from some points of view so formidable and such a reproach to the Government, has arisen from neglect of the subordinate officers personally to see to the enforcement of instructions and regulations sent out by the chiefs of the medical department. Besides this, the soldiers by their disregard of the commonest rules of hygiene have, in numberless cases, brought upon themselves unnecessary and avoidable disease. Be this as it may, it is to be hoped that they will be more careful in observing proper precautions against recurrence of attacks and against spreading infection when freed from the restraints of camp and hospital life. We fear not. We fear also that the same injudicious kindness of relatives which has demanded their return before convalescence has been fully established will kill many of them unnecessarily.

We do not know whether it is being done, but it seems to us that a very simple and effectual way to ward off much of this danger would be to furnish each patient on his leaving the hospital with a printed list of simple instructions for the guidance of himself and friends, as to diet, etc., and more particularly as to the necessity and means of disinfecting everything which is known as a possible medium of infection. Many of the returning soldiers live in out-of-the-way localities, where the services of a physician are not apt to be sought for one who considers himself convalescent, and where, therefore, neglect of necessary precautions is more than likely to be followed by disastrous consequences.

We have, then, here a very widespread immediate cause of disease, while a no less general predisposing cause must be recognized in the weather conditions which have so universally prevailed during the past summer.

"All averages to the contrary notwithstanding," there can be no dispute of the fact that this summer has distinguished

itself by unusually protracted periods of intense heat and humidity, with very few and short intervals of more endurable weather. Although these conditions have not produced any epidemics as yet, or any marked increase in the amount of sickness, their ultimate effects, we fear, are still to come. Their enervating and depressing influence will be shown in a general lowering of vitality and in a weakening of the powers of resistance to disease. Even in the very limited opportunities enjoyed by a doctor in the city in the dog-days, we think we have noticed this tendency. Under these circumstances, where infection is possible it will become certain, and more or less circumscribed epidemics of typhoid are to be looked for. In those localities where *enlightened* City Councils and Boards of Health have eliminated to a great extent the danger of typhoid by attention to the water supply, we would expect to find, as the result of the weather conditions, an unusual prevalence of hepatic disorders, while the conditions are favorable for rheumatic complaints and respiratory troubles. But these "probabilities" are likely to be as reliable as many of the weather-forecasts with which our hearts and hopes have so often been deluded. Time alone will show, but careful observations, made and collected by members of our profession in all points of our extended country, if carefully collated from the standpoint we have here taken as to the two factors at work, ought surely to be of value.

If we homœopaths have had but little to do with making the medical history of the war,—fortunately for our reputations, we think,—we can at least seek out of its consequences to gain something which may be serviceable to science and to ourselves.

---

DIAGNOSIS OF MIDDLE-EAR TUBERCULOSIS.—Winckler says that this diagnosis is full of difficulties, especially in the early period of the disease.

The following symptoms are suspicious :

1. Sudden loss of hearing on one side, with osseous conductivity retained.
2. Paralysis of the facial nerve, with drum membrane intact.
3. Multiple perforation of the membrane occurring painlessly, the membrane being highly reddened and swollen (in simple otitis media the perforation is single, and occurs with great pain). The bacillus is found only when there is a perforation, which makes it possible to mop up the secretion directly from the tympanic cavity.—*Weiner Med. Presse*, No. 18, 1898.

## CLEANINGS.

---

**BLOOD-STAINS.**—The most important blood-stains in use now are those of Ehrlich, Chenzinsky and Huber. Their formulas are not universally known, and yet it is important that the investigator should be able to prepare the stains he uses in order to have them fresh. Old stains are often very unreliable. We subjoin, therefore, the formulas for these stains.

1. Ehrlich's Neutrophile Stain :

Orange G., . . . . .	135 grains.	
Aqua destill., . . . . .	100 grains.	M.
Acid fuchsin, . . . . .	65 grains.	
Alcohol (absolute), . . . . .	100 grains.	
Dist. water, . . . . .	100 grains.	M.
Methyl green, . . . . .	125 grains.	
Dist. water, . . . . .	100 grains.	M.
Absolute alcohol, . . . . .	100 grains.	
Glycerine, . . . . .	100 grains.	

As indicated, mix the first three, each separately, and, after a solution is obtained, mix all four. Now let them stand several weeks, and they will be ready for use. Where absolute alcohol is indicated, and none is to be had, take a little larger quantity of 95 per cent.

This stain is not always "at its best;" why, we do not know. If properly made and used, it will stain the red blood-cells a reddish-brown color. Of the leucocytes, the eosinophile granule will be red, the neutrophile will be violet, and the nuclei green.

The stain is used as follows : Prepare cover-glasses in the usual way ; fix the blood by placing them on a copper plate heated to 212° F. ; leave them there 15-30 minutes ; then place on stain 15-25 minutes ; wash, dry, and mount in Canada balsam.

2. Chenzinsky's Eosine Methyl Blue Stain :

Saturated aqueous solution methyl blue, . . . . .	44 c.c.	
Eosin solution, . . . . .	20 c.c.	
Aqua destill., . . . . .	44 c.	M.

The eosin solution is made by adding to 1 ounce 70 per cent. alcohol 2½ grains eosin.

Directions for use are nearly the same as for Ehrlich's Neutrophile Stain, except that the time for fixing is one hour and for staining twenty-four hours.

All nuclei will be stained blue by it, and eosinophile granules and red



blood-corpuscles red. It does not present as nice a picture under the microscope as Ehrlich's Stain.

### 3. Huber's Stain :

Glycerine,	. . . . .	30 grains.
Aurantia, .	. . . . .	2 grains.
Indulin, .	. . . . .	2 grains.
Eosin, .	. . . . .	2 grains. M.

Use as Ehrlich's Stain ; only allow stain a little more time. This stain is not much used.—Dr. C. Ott, in *Med. Arena*.

TUBERCULOSIS OF THE KIDNEY—EARLY DIAGNOSIS—OPERABILITY.—Dr. Goldberg, of Cologne, from experience in two cases, states that the urine from tuberculous kidney may still be clear. Initial cases may be given the benefit of antituberculous measures before operating, as kreasote, ichthyol, together with dietetico-hygienic measures. Tuberculosis of other parts of the body does not contraindicate.—*Centralblatt F. D. Krankheiten der Harn- und Sexual Organs*, Bd. viii., Hft. 9, 1898.

Dr. Nimier, of Paris, reported to the Société de Chirurgie of that city the case of a man of twenty-one years who five years previously had received a blow on the left hypogastrium. Violent pains kept him for a long time in bed, and his urine was bloody. The urine cleared up, but as soon as he left his bed to go to work it became again bloody. This recurred during the whole five years, so that when coming under observation he was anæmic and weak. Cystoscopic examination revealed nothing. The left kidney was extirpated, but the condition remained the same. The extirpated organ only revealed inflammatory changes, probably of tuberculous origin. He advises never to remove a kidney without catheterization of the ureters. Dr. Pothérat treated an old lady for renal hæmorrhage. The right kidney was easily palpable, therefore he thought it the diseased one and extirpated it. It was four times as large as the normal. The patient passed clear urine for a while, and then gradually developed uræmic symptoms and died. The disease was a chronic interstitial nephritis, which was associated with hæmorrhage from the kidney. (I know of a case of chronic interstitial nephritis with hæmorrhage from the bowels. We have all met with those with hæmorrhages from the lungs.) In another case, where in a young woman hæmaturia had persisted for four years, it was determined, by catheterization, that the right kidney gave issue to the blood. Later, in attempting vainly to catch the urine separately from both kidneys, the hæmorrhage ceased suddenly, she recovered visibly, and has remained well since. Dr. Gérard-Marchant reported a case where nephrotomy caused a hæmorrhage from a tuberculous kidney to cease. Dr. Reynier has several times found renal tuberculosis to be the cause of hæmaturia (renal) in young persons.—*Bulletins et Mémoires de la Société de Chirurgie de Paris*, June 14, 1898.

ANOTHER CASE OF THROMBOSIS OF THE INFERIOR VENA CAVA.—Dr. Jens Bugge, of Christiania, observed a sailor of forty-two years who, formerly well, fell eighteen feet into the hold of a vessel. Violent pains and paræsthesia of both legs followed. He remained several months abed. About a month after the accident œdema and varices appeared about the ankles. After eighteen months his abdomen began to become covered with dilated and

tortuous veins, which increased in size. Now on each side of his abdomen the circumflex iliac veins have so increased in size as to present large tortuous and serpentine cords of the thickness of one's finger. Commencing somewhat below Poupart's ligament, they rise upwards and divide into several branches, of which some are continued into the long thoracic vein, while others reach up to the thorax, and even above. The inferior epigastric and xiphoid veins are also enlarged. The circumumbilical and the truncus anastomoticus lumbo-vertebralis are not larger than normal. There is considerable œdema, as well as numerous varices about the ankles. There is no accompanying liver affection. The writer diagnosed an occlusion by thrombosis of the inferior vena cava. He points out the difference between the distention of the abdominal veins caused thereby and those due to disturbances of the circulation of portal vein.—*Norsk Magazin for Lægevidenskaben*, No. 7, 1898.

**APPENDICITIS DURING PREGNANCY.**—Prof. Pinard, of Paris, states the diagnosis of appendicitis during pregnancy to present no especial difficulties. The fœtus generally dies and is expelled. Operative interference should be done more quickly than in any other associated condition. Out of thirty operated on, twenty-one died. Of these, twenty-two had encapsulated and eight general peritonitis. Of fifteen not operated on, four died; of these, two had general peritonitis. Since Mundé called our attention to the special dangers of appendicitis in pregnancy about forty-five cases have been recorded, chiefly by American and French writers.—*Le Bulletin Medical*, No. 24, 1898.

**THE DIFFERENTIAL DIAGNOSIS OF CYSTITIS AND PYELITIS.**—Dr. G. Rosenfeld, of Breslau, taking exception to the statement of Posner, in his work, *Diagnostik der Harnkrankheiten*, Berlin, 1894, that we are unable to determine the source of pus in the urine, set forth the following differential features between cystitis and pyelitis:

1. A urine which is not acid does come from an uncomplicated pyelitis.
2. Pus corpuscles, if round and filling the whole microscopic field, are of decided pyelitic origin. If, on the contrary, they be, amoeboid-like, distorted, they distinctly point to a pyelitis as their origin.
3. Well-preserved red-blood corpuscles may be derived from the vagina, urethra, or bladder—except a bladder tumor—destroyed, morphotically disintegrated ones are from the pelvis of the kidney—if no nephritis be present.
4. The epithelium is essentially of secondary importance diagnostically.
5. The quantity of albumin and its relation to the amount of pus is of the greatest importance diagnostically. With a sediment of pus one inch thick from a cystitis, the quantity of albumin will never be more than 0.1 per cent., and at the most never over 0.15 per cent.
6. With a pyelitis the quantity is always greater, from 2.21 to 2 per cent., even 3 per cent., with the same quantity of pus. This is the characteristic differentiating feature. Only clumps of small epithelia are significant of pyelitis.—*Berliner Klinische Wochenschrift*, No. 30, 1898.

**A CASE OF TETANUS FROM A RARE CAUSE.**—Dr. Bandisch was called to a gardener of fifty years who was previously robust and healthy, but who, to relieve a toothache in a carious tooth, had been in the habit of boring in the cavity with a pointed stick until blood flowed. When seen he complained

of heaviness in his legs, stiffness of the neck and sleeplessness, but he was also unable to open his mouth more than three-quarters of an inch. Three days after his state had aggravated. His legs jerked so that he could not walk across the floor. Eating was almost impossible, on account of the spasm of the masseters and the painfulness and difficulty of swallowing. There was a tendency to opisthotomis and clonic spasms of the lower extremities. The reflexes were greatly aggravated. Shaking the bed or loud calling would bring on a spasm. The symptoms greatly resembled strychnine poisoning. But the detection of the mentioned carious tooth and the manipulations with the dirty peg led to extraction of the tooth under chloroform anaesthesia. The symptoms gradually decreased in severity. During the next few days the violent symptoms decrease, so that in the following three weeks he had wholly recovered. The germs of tetanus are said to remain in the wound itself, sending their toxins out through the system. Hence the favorable results from the extraction of the tooth.—*Berliner Klinische Wochenschrift*, No. 31, 1898.

FRANK H. PRITCHARD, M.D.

USE DIPHTHERIA ANTITOXIN PROMPTLY AND BOLDLY.—We are now prepared to occupy and defend the most advanced position, namely, that without waiting for bacteriological confirmation of diagnosis, every patient who presents clinical evidence of diphtheria should at once receive a "curative dose" of serum, and all children of the household should be immunized by the same agent. Adults should be immunized if likely to be much exposed, and may be immunized, if they desire it, even if not specially exposed.

It is of the highest importance to have a trustworthy serum, of as high potency as possible, so that a dose small in bulk shall be large in antitoxic units.

For a child of three years, the initial dose in a tonsillar case of moderate severity seen early should be 1000 to 1500 units; in nasal or laryngeal cases, or in cases in which the lower pharynx is invaded, or severe cases of any variety, the dose should be 2000 units; and in any case first seen as late as the fourth day, the dose should be 2000 to 3000 units. The injection should be repeated in from twelve to twenty-four hours, according to circumstances. For immunizing, 500 units should be the dose; or if infection and incubation be suspected, the curative dose of 1000 units should be given at once. What is needed is promptness and courage in the use of the remedy.—Dr. Cohen, *Philadelphia Polyclinic*.

PAPOID.—Prof. Finley Ellingwood, M.D., Chicago, Ill., remarks upon the above plant as follows: A cultivated tropical fruit tree, twenty feet high, fifteen inches diameter. The juice contains the important medicinal principle. It is best obtained from the unripe fruit, which yields about one ounce to each single fruit. It is of a milky character, with slight acid reaction, and a bitterish, astringent taste. The heavier portions soon coagulate and separate, leaving a watery portion which contains the active principles of the juice. "This active principle has been variously named *papain*, *papaotin*, *papoid*, or *caroid*. It is precipitated by alcohol, is a nitrogenous principle approximating in character a true albuminoid, and is associated with vegetable peptones and a milk-curdling ferment. The action of the juice upon milk coagu-



lates it, then separates the coagulum, and finally quite quickly digests it. The active principle of the juice acts in the same manner as the juice, but more perfectly in the digestion of food. It is a vegetable digestive of extreme potency, in many cases accomplishing results not accomplished by the animal ferments. It is a powder of a cream-white color, almost odorless, and with but little taste. It is easily soluble in water, and also in glycerin. This active principle has no action on living tissue, and is non-toxic—is, in fact, innocuous in any reasonable quantity—although it is claimed to produce the death of animals if introduced into the venous circulation. It differs from pepsin in that it acts in fluids of an acid, alkaline or neutral reaction with nearly equal facility, but working the best in an alkaline medium.”

It emulsifies fats and promotes pancreatic digestion. It converts starch into maltose, etc., and peptonizes albuminoids. It stimulates the secretion of the natural digestive ferments. It is an antiseptic and prevents fermentation.

He summarizes the uses of papoid in treating digestive disorders as follows: In actual and relative deficiency of the gastric juice or its constituents. (a) Diminished secretion of gastric juice as a whole; apepsia, anæmia and deficient blood supply, wasting diseases. (b) Diminished proportion of pepsin; atonic dyspepsia; atrophy of gastric tubules. (c) Diminution of hydrochloric acid; achlorhydria; carcinoma. (d) Relative deficiency of gastric juice; overfeeding.

In gastric catarrh. (a) When there is tenacious mucus to be removed, thus enabling the food to come in contact with the mucous membrane. (b) Where there is impaired digestion.

In excessive secretion of acid, to prevent duodenal dyspepsia.

In gastralgia, irritable stomach, nausea or vomiting.

In intestinal disorders. (a) in constipation due to indigestion; in diarrhœa, as a sedative. (b) In intestinal worms.

In infectious disorders of the intestinal tract. (a) Where there is abnormal fermentation, by its antiseptic action, which may be heightened by combination. (b) Where there are foreign substances present, its detergent effect may be utilized in clearing out the *debris* from the intestinal contents by digestion.

In infantile indigestion. Here papoid not only readily peptonizes cow's milk, but the resulting curds are also soft and flocculent, resembling those of breast milk.

The dose of papoid is one or two grains, but five grains or more may be used, the only objection being that of useless expense and waste, except where very prompt effects are desired, in which case even larger doses of the remedy may be administered. In case of the obstruction of the œsophagus by an impacted piece of meat and gristle—such as have been recently reported, a paste of papoid and water would produce softening in a short time.—*Eclectic Medical Journal*, July.

W. D. CARTER, M.D.

THE TREATMENT OF ULCER OF THE STOMACH.—Ewald, of Berlin, considers ulcer of the stomach one of the most satisfactory affections to treat, provided, of course, that it be not too old, and that the depth of the ulcerative process has not already given rise to cicatricial contractions and adhesions. According to the method pursued by him, the patient is confined

absolutely to bed for the first five or six days, and receives as nourishment only nutritive enemata, which are given in the usual way, three or four times a day. Thirst is combated by small pellets of ice, the feeling of hunger by a few drops of a solution of cocaine. It is remarkable, however, how slight these sensations are, as a rule. If the pain continues at the beginning, a small injection of morphine in the region of the stomach yields the best results. As a rule this is not necessary, as the pain ceases spontaneously as soon as the mechanical irritation of the ulcer stops. This pain constitutes an excellent differential diagnostic symptom for nervous cardialgia and biliary colic, which are often deceitfully like ulcer of the stomach in their symptoms. Nervous gastric pain will be influenced not at all, or only for the moment, by the withdrawal of food, *i. e.*, so long as the suggestive effect of the novelty of the treatment continues.

After no food has been given by the stomach for from three to five days, according to the subjective symptoms and the general condition, a few teaspoonfuls of some easily absorbable material are given. The simplest is a plain milk-gruel of some meal or other, wheat or oats, or mondamin, or one of the many artificial preparations, Kemmerich's peptone, or somatose, or nutrose, or eucasin. If this causes no pain, the next day more is given. After three or four days other easily digestible substances are added, but at first in more or less liquid form. Then the consistency of the food is increased, and the nutritive enemata become fewer in number.

Should pain occur, however, after the first trial, then exclusive feeding by the rectum must be resumed, and in some cases the author has kept it up for from ten to fourteen days. You cannot hope in such cases, however, to retain your patient's equilibrium for so long a time. A considerable loss of weight ensues, but this loss is of little importance and is soon made good. The original body-weight is far outstripped when the patient is able to eat plentifully without pain.

This method of treatment should be carried out whenever it is possible. It gives such excellent and certain results that one can say when it fails that complications must be present, *e. g.*, old cicatrices, especially at the pylorus, perigastric adhesions, or else that some other affection, whose seat is perhaps not in the stomach at all, must be the cause of the pain.—*Philadelphia Medical Journal*, August 13, 1898.

IS SUNSTROKE AN EPIDEMIC DISEASE?—A startling departure from the general conception of the etiology of sunstroke is made in a paper recently contributed to the *British Medical Journal* by L. Westeura Sambon. Dr. Sambon believes that heat exhaustion, one form of so-called "sunstroke," is merely a syncope, and that thermic fever, the other form of sunstroke, is a specific infectious disease, to which he gives the old name for sunstroke, *viz.*, siriasis.

In syncope the skin is moist, pale and cool; the breathing, though easy, is hurried, the pulse small and soft, the temperature is normal or slightly below normal, the pupils dilated, and the loss of consciousness is complete. Though death may occur, an immediate recovery is the rule. Siriasis, on the other hand, is characterized by a high temperature, profound coma and intense pulmonary congestion, and its mortality is exceedingly high. It prevails in the hot season, and occasionally in an epidemic form.

According to the author the symptoms of the disease, its relapses, the morbid anatomy, its peculiar geographical distribution, its epidemic outbursts, the conditions of climate and soil under which it prevails, the relative immunity to its attacks afforded by acclimatization, all clearly point to the specific infectious nature of the disease. In conclusion Dr. Sanbon holds that the specific organism of siriasis is probably spread in the superficial layers of the soil, like other pathogenic micro-organisms, and may be conveyed to man with dust blown by the wind or thrown up under the tread of a marching column. It is then inhaled into the lungs, or ingested into the alimentary canal, where it produces the deadly toxin which probably, as in cholera, becomes absorbed and sets up the symptoms of the disease.

This conclusion will be a startling one to many who have had to deal with sunstroke, but the author adduces such an array of evidence in its support that it deserves most careful study.—*Gaillard's Medical Journal*, June, 1898.

F. MORTIMER LAWRENCE, M.D.

**VARICOCELE.**—Dr. Monroe Manges complains that most patients suffering with this complaint present themselves to the family doctor only after they have exhausted all their funds on the advertising quacks. He says that physicians should instruct their patients properly and try to make known to the public the following facts :

1. That every varicocele can be cured by an operation.
2. That a varicocele that has existed for some time can never be cured without an operation.
3. That the operation is without danger to the patient, and, contrary to the fear and belief of the patient, that the sexual power and health of the testicle is increased by the operation.
4. That the operation is always a success when properly performed.
5. That the patient is disabled only a week or ten days.
6. That all symptoms and suffering leave the patient at once ; the sweating, coldness, itching and eczema of some cases cease at once ; all nervousness, sleeplessness and worry cease instantly.

He reports fifty-three cases without a serious complication.—*Alkaloidal Clinic*, July, 1898.

**SURGICAL HINTS.**—In wounds of the head, always inspect the scalp carefully before applying a dressing. If parasites are present they may convey infection, and the irritation caused by their presence may cause the patient, especially if young, to disturb the dressings. If present, it is best to shave the head. If this is not permitted, kerosene will kill them very rapidly. After a thorough application of this, wash off with green soap and water, then with sterile water alone.

In gangrene of senile people, if it is decided that amputation is not advisable, it is usually best to wash the gangrenous part several times a day with a deodorizing antiseptic, and leave it exposed to the air. It will then become dry, avoiding the stench always present under thick dressings. If pain is prominent, give opium, which often seems to arrest the progress of the disease.

In an emergency operation, in which it is necessary to operate under anæsthesia shortly after the patient has eaten, wash out the stomach if possible.



It is not usually best, if no stomach-tube is at hand, to cause emesis, excepting in children, as adults who have just vomited take the anæsthetic badly, and emesis is a trying ordeal for most adults.

Wherever iodoform or any of the iodine compounds is applied as a dressing, the part should be inspected the next day, owing to the possibility of the occurrence of dermatitis. When the latter occurs it often gives rise to heightened temperature, and might lead to the belief that wound infection had taken place.

In the absence of organic disease, the ability of a patient to stand severe surgical operations depends greatly upon the state of his blood-vessels. Hardened arteries in middle age place the patient, for surgical purposes, in the class of old men. "A man is as old as his arteries."

It is well known that some injuries are especially likely to be followed by shock. In the presence of such injuries, even if the patient shows no shock, take every precaution against a condition which is apt to arise at any moment.

Statistics appear to show that chloroform is less dangerous in warm than in cold countries. It is therefore always advisable, whenever for any reason chloroform is to be preferred to other anæsthetics, to see that the operating-room has a high temperature.

Infection in deep tissues often gives rise to no other symptom than deep pain, and sometimes inability to move the part. Wherever there is deep pain with rise of temperature inspect the nearest lymphatic glands.—*International Journal of Surgery*, September, 1898.

**IMPROVED METHOD FOR STERILIZING SILK AND CATGUT SUTURES.**—Silk and catgut sutures can be sterilized perfectly, but there is always danger of contamination in transporting them from the tanks and pans to their ultimate destination in the tissues operated on. Neither have we in our possession the means of rendering inert the pathogenic germs already existing in the body; consequently stitch abscess and suppuration still confront us.

In order to produce, if possible, ligatures that would overcome these difficulties, we made a series of experiments in the Pathological Laboratory of the Chattanooga Medical College, and found the results obtained with glutolized sutures so favorable that we now use them in abdominal work as well as minor surgery.

In seeking to perfect the sterilization of sutures, the power of formaldehyde to form with gelatine an insoluble combination (glutol) was taken into consideration. This substance, when subjected to the action of living tissues, gives up its formaldehyde, thus converting the wound itself into a laboratory where a powerful sterilizing agent is constantly produced. The process for making the preparation is the same as that employed for making glutol. While the preparation is still liquid, the sutures for sterilization are introduced and left for twenty-four hours, after which they can either be removed, rolled up and put away in sterilized jars, or left in the preparation and used directly therefrom. If put into jars, these vessels should contain a piece of filter-paper in the bottom, saturated with paraldehyde.—H. Berlin, M.D., in *Virginia Medical Semi-Monthly*, August, 1898.

**RECURRENT GONORRHEA.**—Dr. Fred. C. Valentine, in an article on the above subject, says:

1. Cessation of the symptoms of clap does not prove that the case is cured.
2. No female cured of the evidences of clap should be dismissed without proving that the apparently normal urethra, Bartholini's glands, the cervix and sub-mucous tissues (especially those of the cul-de-sac) are free from gonococci.
3. No male should be dismissed from treatment until it is definitely ascertained that his urethra, seminal vesicles and prostate are free from disease.
4. The methods of securing positive evidence of the cure of gonorrhœa are within the general practitioner's reach.
5. The treatment of recurrent gonorrhœa is not difficult, nor does it require special skill.

The principal causes of recurrent gonorrhœa are :

1. Marital reinfection.
2. Infarction of crypts, glands, or follicles of the anterior urethra.
3. Chronic residual posterior urethritis.
4. Gonorrhœal prostatitis.
5. Seminal vesiculitis.

Any two of these causes may be united in one case.—*Atlanta Medical and Surgical Journal*, September, 1898.

W. F. BRIERLY, M.D.

DIAGNOSIS OF STONE IN THE BLADDER BY SKIAGRAPHY.—Dr. Frisch, from photographing several stones in the bladder with the Roentgen rays, concludes that the uric acid stones yield a light-colored shadow, while the oxalates give a dark-colored one. The amorphous phosphates photograph quite a dark, and those formed of the crystalline phosphates a lighter.—*Gyógyászat ; Roentgensugárak holyág es vesekoeveknél*, 26 száma, 1898.

A CASE OF RUPTURED UTERUS IN MANUAL EXTRACTION OF THE PLACENTA.—(Dietel.) The patient gave birth to a premature child easily and rapidly at 1 A.M., but as the midwife was not able to extract the placenta she called a neighboring physician at 3 o'clock, who also failed to extract it. He summoned a second physician at half-past four, and administered a narcotic, while the second physician undertook the manual extraction of the placenta. He apparently met with considerable difficulty, and could only remove it piecemeal. The patient lost considerable blood and received several hypodermics of camphor. At six o'clock she became conscious, and the physicians left the patient. At nine o'clock a colleague gave another hypodermic of camphor, and ordered the patient removed at once to the Woman's Hospital. Dietel examined at once, and found a split in the uterus near the promontory of the sacrum. Prof. Zweifel performed a laparotomy half an hour later. There was a large quantity of blood in the peritoneal cavity, also a large laceration in the right broad ligament, which was closed by several catgut sutures, though it no longer bled. Further inspection showed that the small intestine was torn from the mesentery for 65 c.m. It was blue-black and lustreless, and there was considerable bleeding from the vessels belonging to the mesentery. The vessels were ligated, and the intestine was rapidly resected and the ends united by Murphy's button. Finally, there was a laceration in the right meso-ovarium and meso-salpinx, and the right round ligament was torn away. The abdominal wall was closed and a saline transfusion given. The patient died a few hours later. Subsequent examination of the uterus showed most

of the placenta adherent to the fundus uteri and firmly attached to the posterior surface. It is probable that the attending physician pulled on the cord and partly separated the placenta from the uterine wall, and perforating the uterus about the level of the internal os reached the right broad ligament and mistook the round ligament and tube for the umbilical cord and the mesentery for the placenta. Generally speaking, the manual separation of the placenta is an easy operation, requiring little skill; but it is to be performed correctly and without force, and always with a definite plan of operation in mind. There should never be traction on the cord, and the placenta should always be removed step by step with the ulnar border of the hand, with counter-pressure externally. All manipulations with the tips of the index and little fingers are to be condemned. The external hand must always support the internal hand. Many young physicians do not understand the anatomical relations of the recent puerperal uterus. They do not know that the cervix hangs as a relaxed flabby tube on the firmly-contracted uterine body, and that the muscular tissue of the body projects forward and over it like a ridge. Many a beginner has mistaken this muscle-ridge for the margin of the placenta.

GEO. R. SOUTHWICK, M.D.

**ATROPIN-CONJUNCTIVITIS.**—Mark, Jacob, says that in Schulek's clinic the borate of atropin is used. Atropin-conjunctivitis is supposed to be caused by bacteria used in old solutions. He cites two cases from Ahlström's, and also two original cases, in which sterile aseptic atropin solutions had caused conjunctivitis. This he ascribes to individual idiosyncrasy.

He saw one patient in whom one drop of atropin solution would each time produce an intense conjunctivitis.

The causation in conjunctivitis from atropin is on account of its effect on the vessels and nerves of the membrane, which lowers the tone of the vessels; so by this means a catarrh may arise from slight irritation. Graefe has shown that this drug produces anatomical changes, and the irritability of the conjunctiva is made greater. If the membrane is saturated with atropin an extra drop may cause intense inflammation, and this irritability may last many months.—*Budapester Med. Chir. Press*, 1897, 51 and 52, 1898.

**HYSTERIA COMBINED WITH REFLEX PARALYSIS OF THE PUPIL.**—There have been few cases reported in which during an hysterical attack paralysis of the pupil has been observed.

Cases are more rare in which this symptom appears with the attack. In all these cases the paralysis of the pupil has disappeared.

In Oppenheim's case it has remained for fifteen years, and should not be denominated hysterical, as fifteen years before the patient had brain syphilis, which was cured by inunction. This case is especially interesting, as since this time this person has had no further indications of syphilis.—Oppenheim, *Zeitsch. f. Prakt. Aerzte*, No. 6, 1898.

**EUPHTHALMIN AND MYDRIATICS OF SHORT DURATION.**—For diagnostic purposes homatropin, cocain and ephedrin, and lately euphthalmin, are to be preferred to atropin and scopolamin, on account of the long effects of the latter.

Evanescent dilatation of the pupil without paralysis of accommodation, without other effects of the eye and its appendages, should be the properties of a pure mydriatic. Euphthalmin seems to best fit this description.



There are no subjective complaints, injury to the cornea, or general disturbances, such as have been observed from the use of cocain, when euphthalmin is exhibited. Euphthalmin is superior to homatropin, in that it passes away more quickly and does not increase the intraocular tension. It may be used in glaucoma without fear. The only after effect from use of euphthalmin is in the diminution of accommodation. This, however, passes away rapidly, and in young persons never reaches such a grade that neat work cannot be done.—P. Schneider, *Zeitsch. f. Prakt. Aerzte*, March 15, 1898.

THE INFLUENCE OF HOLOCAÏN UPON DIFFUSION OF FLUIDS FROM THE CONJUNCTIVAL SAC TO THE ANTERIOR CHAMBER.—Snequirew has found by Bellarminoff's method that holocain favorably influenced and increased diffusion from the conjunctival sac into the anterior chamber, and concluded that the combination of holocain with atropin or eserin would produce more favorable results than when these drugs were combined with cocain.—*Die Ophth. Klinik*, May 5, 1898, Moscow Ophth. Soc.

THE OCCURRENCE OF GLAUCOMA IN EYES WITHOUT CRYSTALLINE LENS.—Inasmuch as in the greater number of cases the development of glaucoma, associated with aphakic eyes, is to be considered secondary, it is clear that an uneventful healing after cataract operations is the most certain preventive of such secondary glaucoma. Especial attention should therefore be given to the hands of the operator, careful incision, complete reposition of the iris, careful cleaning of the wounds, etc. In the hyperopic eyes of old people with dry chambers, iridectomy is thought advisable.

If a secondary cataract develops, discision should be practiced early, with precautions mentioned; possibly by such preventions latent glaucoma may be avoided. Cases and authorities are cited in support of this proposition.—H. Bernheimer, *Wien. Klin. Woch.*, April 28, 1898.

ATROPINE RHINITIS.—This is a form of irritation of Schneiderian mucous membrane and turbinal cavernous tissues caused by the leakage of atropine through the lachrymal duct when used for mydriatic purposes.

Like atropine conjunctivitis, it occurs only in those having idiosyncrasy for the drug. The mucosa is dry, glazed; cavernous tissue of turbinals become more red, but there is a total lack of secretion; as application is continued there is a sensation of heat and discomfort in nostrils; objectively turbinals are congested and secretion increased.

As it paralyzes unstripped muscles it leaves a more or less permanent hypertrophy of turbinal venous sinuses, in other words, of turbinal varix.

The nasal discharge is excoriating. In chronic conditions the mucosa is gray, soggy and macerated, and comes off in flakes.

Treatment: discontinuance of the drug and soothing applications.—LEWIS S. SOMERS—*The Laryngoscope*, October, 1897.

FORMALDEHYDE IN HAY FEVER.—In this remedy the author has found an excellent adjuvant. He uses a one-half per cent. solution of the commercial article as a spray, and directs the patient to inhale the fumes from a 2 per cent. solution contained in a one-drachm vial.—ALEXANDER—*The Med. Summary*, Vol. xx., No. 4.

WILLIAM SPENCER, M.D.

## MONTHLY RETROSPECT

### OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

---

**FLUORIC ACID IN WHITLOW.**—According to McLachlan, cases of whitlow where fluoric acid, the one remedy that has actually produced that lesion during its proving, is likely to be of use, are relieved by washing or sponging with cold water, and aggravated by the application of heat. It seems to affect the fingers of the left hand rather than those of the right, and the pus tends to point on the dorsum of the finger. The “pointing” on the dorsum is a real thing, and not a mere sympathetic cellular tissue abscess. It is possible that incisions are frequently made into the pulp of the ungual phalanx of the finger when the pus is really on the dorsum. This mistake arises from the sense of fluctuation yielded by the pulp of the swollen finger covered by its thickened cuticle, even when no fluid is present. Fluoric acid and silica are both useful in bone felons, but observe that silica is aggravated by cold applications and ameliorated by warmth—the reverse of fluoric acid. Fluoric acid is also useful in cases of onychia, resulting in deformity of the nail, as often happens in cases of paronchia ungualis.—*Hahnemannian Advocate*, June 15, 1898.

**REMEDIES FOR ACUTE INANITION.**—Linn, of Des Moines, recommends in connection with the attention to nutrition and other adjuvant treatment the use of arsenic, lachesis, calcarea carb., china, nux vomica, phosphorus, iodine, rhus tox. and thuja. As an addition to this list Crosby, of Cannonsburg, Mich., suggests baryta iodide, which has in his hands done excellent work in correcting the mal-assimilation. Two cases are recorded in evidence of the value of the remedy.—*Medical Era*, July and August, 1898.

**THE TREATMENT OF SENILE CATARACT.**—In the choice of a remedy for senile cataract Baker, of Washington, suggests the following as guiding symptoms:

*Baryta carb.*—Cataract associated with glandular affections. Degenerative changes in the coats of the arteries.

*Calcarea fluor.*—Cataract associated with calcareous deposits on bones or in joints after rheumatism. Evidences of malnutrition of teeth. Varicose veins. (Use locally and internally.)

*Causticum.*—Feeling of sand in the eyes. Veil before eyes in rheumatic subjects, with tendency to paralysis. Sensation of pressure or heaviness of lids. Dyspepsia. Flashes of light.

*Calcarea phos.*—Dyspepsia. Chronic rheumatism. Right eye worse.

*Conium.*—In traumatism, to prevent formation of traumatic cataract.

*Fluoric acid.*—In cataract of drunkards with broken-down constitutions. In incipient cataract, when vision seems clearer. Crumbling of finger-nails; or they have longitudinal fissures.

*Jaborandi.*—Asthenopia, with cataract. Distant vision seems more blurred than near. Hyperopia. Vision gets better, then worse. After suppression of secretions.

*Lycopodium.*—Uric acid diathesis, emaciation, vision worse in the evening, but sunlight hurts the eyes. Acid dyspepsia. Chronic constipation.

*Phosphorus.*—Inflammation and atrophy of kidneys. General debility. Vision better in the morning. Oil-like spots in lens. Green halo. Letters appear red. Black floating spots.

*Pulsatilla.*—Non-inflammatory rheumatism, worse in evening, better from cold and worse from warmth. Catarrh of eyes and nose. Progressive cataract. Sluggish circulation. Phlebitis. Suppression of any bloody discharge. Sweating of legs.

*Senega.*—Paralytic symptoms everywhere. Opacities of vitreous. Promotes absorption of lens fragment after operation. Urine diminished, and turbid on cooling.

*Sepia.*—Inactive liver. Herpetic eruptions. Jaundice. Emaciation. Dark hair. Intolerance of reflected light. Green halo. Weakness of upper lids. Morning and evening aggravation. Cataract in women.

*Silica.*—In cataract with spinal irritation, sometimes with albuminuria and diabetes. Finger-nails yellow and brittle. Senile cataract, or the result of sudden suppression of sweating of feet, or with any eruption.

The writer has used cinerarum mar., but so far with no perceptible beneficial results. The above remedies can be given with advantage with boric acid wash.—*Hom. Eye, Ear and Throat Journal*, July, 1898.

HEPAR SULPHUR IN "COLDS."—Hepar is useful in that form of catarrh when there is aching all over the body. It should be here placed, not as a remedy useful in the incipency, but for the advanced stage of "cold." If it be given at the commencement it frequently spoils the case, whether it be one of coryza or of sore throat, because it is more suitable to what has been termed "a ripened cold," when phlegm has formed. Swallowing produces the sensation of something sharp being in the throat; it is often likened to a fish-bone. Again it will seem as if there was a crumb of bread there. Here we should compare mercurius, nitric acid, argentum nitricum and alumina. The colds for which hepar is the remedy are re-excited by the least exposure. When mercury has been abused there will be an additional indication for the choice of hepar.—*Hom. Eye, Ear and Throat Journal*, July, 1898.

F. MORTIMER LAWRENCE, M.D.

IODINE IN TUBERCULOUS MENINGITIS.—Dr. Schoenebeck, at a recent meeting of the Association of the Homœopaths of Northern Germany, reported the case of a child of five years who, according to an allopathic diagnosis, had a hemiplegia. There was right-sided hemiplegia (also noticed in tuberculous meningitis as a symptom only), a very red face, alternating at short pauses with paleness, a retracted abdomen—*der kahnförmige Bauch*—constipation, pronounced rigidity of the neck, frequent whimpering. The pulse was intermittent—a valuable sign of tuberculous meningitis—a tem-



perature of 38.2 C. in the rectum. He diagnosed meningitis, and gave a very unfavorable diagnosis, as several members of the family were tuberculous. Bell. 3x removed all the signs of hemiplegia; the next day the condition otherwise the same. For three weeks this state remained about the same. After cupr. 6x the play of colors in the face and the intermittent pulse improved. For picking at the nose he gave cina as well as arum, unsuccessfully. In the third and fourth weeks rhythmic movements and twitching of the arms and legs set in, and actual hunger, though the child really was emaciating. These indications led him to select iodine, which brought about a continuous amelioration, which ended in recovery.—*Zeitschrift des Berliner Vereines Homöopathischer Aertze*, Bd. xvii., Hft. 3 and 4, 1898.

FERRUM PHOSPHORICUM (3 & 6x) IN CONGESTION OF THE LUNGS.—Dr. Bonino, of Turin, regards this drug as an analogue of aconite, though its symptoms are more passive. He was called to an old man of seventy-four, formerly a drinker and a smoker, who had suffered from an obstinate gastric catarrh. He had felt quite well until a few weeks before, when he was attacked with spasm of the neck of the bladder and dyspnœa. He went to bed, his pulse was arrhythmic and irregular, scanty and reddish urine, dry cough and complete anorexia. Aurum, f., tereb. and dig. had no effect, and on the sixth day of the disease the cough was still more distressing, with a muco-sanguinolent sputa, the pulse still more irregular, and the respiration assumed a Cheyne-Stokes form. Dulness on both sides of the chest, slight delirium during the occasional somnolent spells. The urine was scanty, turbid and *albuminous*, heat and congestion of the head. These symptoms threatened a fatal termination, and from lack of anything indicating any other remedy the writer left six powders of ferrum phosphoric, one every hour. The action was wonderful. After the second dose the "storm" ceased; the patient then slept several hours restfully. His pulse was regular, although somewhat quick, his urine flowed more profusely, his breathing became much freer, and he was friendly and grateful. This amelioration was no deceptive one, for from that hour his recovery dated, though his digestive organs needed some attention. Ferrum phos. acts in producing a state of semi-paralysis of the blood-vessels, bringing about a condition of stasis which was decidedly present in this case.—*Allgemeine Homöopathische Zeitung*, Nos. 1 & 2, 1898, July 1st.

Unfortunately this case was at a critical turning-point, when it might be that the usual aggravation before a crisis was present, and that the disease pursued its way and changed for the better, *in spite of* the remedy, and not on account of it. Some old wise-head said once that many a young doctor has made his reputation in being called in to a case of pneumonia just before the crisis. Yet it must be admitted that this patient was in a very desperate state, for with *his urine in that condition*, the history of a *chronic and obstinate* gastric catarrh, the *attacks of dyspnœa and irritation of the neck of the bladder*, with the *heart signs and symptoms*, it is highly probable that he had a chronic interstitial nephritis. Such cases I have found some of the most difficult to manage when they become affected with pneumonia. Pneumonia in chronic alcoholics has been long written and talked of, but I must say that such a condition in a chronic opium or morphine-eater is still worse. If

ferrum phosphor. will bring about such a change, then it should be made known. Still there will come a time when in these cases of chronic Bright's disease *natura repugnante omnia vana*.

**VERATRUM ALBUM IN NEURALGIA FACIALIS.**—A man of thirty years, lean, of large stature, had suffered from violent tearing pains in his whole head, concentrating themselves in the left side of the head. During the past six nights they had been so violent that he had been unable to sleep. He appeared to suffer much, with no signs pointing towards either the eye or ear. It was disagreeable to open his eyelids even in the dark; the pains so violently tearing that nothing can be obtained as to their nature. As soon as he goes to bed he breaks out into a profuse sweat over his whole body. Veratr. alb. 3x, fifteen drops in a wineglassful of water every hour and a half teaspoonful, and later every hour, was given. After having taken a few doses he felt easier. That night he went to bed fearing the fearful sweat, but it did not reappear, and he slept excellently the whole night, and awoke the next day with a dull pain in the eye-region, which, with continued use of the remedy, gradually left him. A weakness of the eye remained for some time.—*Homœopathischen Monatsblätter*, No. 8, 1898.

**TREATMENT OF CONSTIPATION.**—François Cartier, of Paris, insists particularly in treating constipation upon general alimentary measures, as eating of Graham bread, prunes, prune juice, fruits, and drinking of beers rich in malt. As to remedies, he advises especially three—lycopodium, bryonia and alumina.

*Lycopodium* is a great remedy in constipation, acting better in a moderately high dilution, the 30x for example. It is indicated in constipation from atony of the abdominal viscera, the liver functionates badly, digestion is slow, especially in the intestines, and the cause is a defective circulation. Particularly constipation of women, where it acts better than in males.

*Bryonia* is of service in dryness of the intestinal tube; the fæces are as hard as balls. They resemble sheep dung. Constipation of infants and youths.

*Alumina* is a good remedy in chronic constipation. There is paresis of the rectum, for the stools themselves are not constipated. There are other drugs with characteristic symptoms.

*Nux vomica*, constipation with hæmorrhoids.

*Plumbum*, obstinate constipation with colic.

*Opium* is useful where the intestine is filled with fæces, but they are so atonic as not to feel them, and thus one experiences no desire for stool.

*Silica* has one peculiar and characteristic symptom. The passage is half evacuated, and re-enters the rectum from weakness of the sphincter. Col-linsonia, hydrastis and other remedies are indicated either in low dilutions or the tincture.—*Revue Homœopathique Française*, No. 7, 1898.

**ARGENTUM NITRICUM** is indicated when there is muco-purulent sputum coming from the posterior wall of the larynx. There is also marked hoarseness, amounting sometimes to complete aphonia. There is a feeling as if something were clogging the vocal organs.

FRANK H. PRITCHARD, M.D.

# THE HAHNEMANNIAN MONTHLY.

---

NOVEMBER, 1898.

---

## SEMMOLA'S VIEWS ON THE PATHOLOGY AND TREATMENT OF BRIGHT'S DISEASE.

BY GEORGE FREDERICK LAIDLAW, M.D., NEW YORK.

### EDITOR HAHNEMANNIAN MONTHLY:

*Sir*: It is the misfortune of the reformer, while living, to be misunderstood by his friends and persecuted by his enemies. When he is dead, enemies and friends are apt to unite in the writing of eulogies and the building of monuments. Dr. Mariano Semmola being now dead, the time has arrived for understanding and appreciating his work. As far as my information extends, there is no satisfactory exposition of this subject in the English language, and I willingly respond to your invitation to present to your readers an outline of Semmola's ideas on the pathology and treatment of Bright's disease, together with the facts on which they are based. Semmola's work has been ignored by English and American authors, and has received but scant attention at the hands of continental writers. The only information accessible to the English reader is found in the translations of the books of Dujardin-Beaumetz\* and Fürbringer,† a paragraph by Dr. Hartshorne in the American edition of Reynolds' *System of Medicine*,‡ a few paragraphs

---

\* *Modern Treatment of Diseases of the Kidney*, Detroit, 1888.

† *Text-Book of Diseases of the Kidneys*, vol. i., London, 1895, p. 25.

‡ Vol. iii., p. 662.



in Dr. Millard's book,\* and in Sajous' *Annual of Medical Sciences*.† All of these references are brief, and all inimical.

Fortunately, we are not dependent upon such unsatisfactory exegesis. Our author has written liberally. My own knowledge of his work is derived from the study of the following essays written by Semmola himself:

*La nature et cause d'albuminurie.* Mémoire présenté à l'Académie de Médecine de Paris, 1861. *Gazette des Hôpitaux*, 1861, p. 569.

*Nouvelles recherches sur la pathogénie et sur le traitement d'albuminurie.* (Académie de Médecine.) *Gazette des Hôpitaux*, 1867, vol. xl, p. 492.

*Nouvelles recherches expérimentales et cliniques sur la maladie de Bright.* (Académie de Médecine.) Parts I. and II. Abstract in *Gazette des Hôpitaux*, 1883, p. 517; abstract in *Progrès Médicale*, 1883, p. 471. Published in full in *Archives de Physiologie Normale et Pathologique*, 1884, vol. ii., pp. 1 and 287.

Part III. of the same. Presented to the Academy in 1886. Abstract in the *Gazette des Hôpitaux*, 1886, vol. lix., p. 840.

*Sur la maladie de Bright.* Transactions of International Medical Congress, Amsterdam, 1879.

*Nouvelles recherches expérimentales et cliniques sur les conditions pathogéniques de l'albuminurie.* Transactions of the International Medical Congress at Washington, D. C., 1887, vol. i., p. 194. Only the "conclusions" appear in the Transactions. An extended *résumé* of the paper may be found in the *Medical News*, 1887, vol. li., p. 441. The complete paper was printed in *Die Deutsche Medicinische Wochenschrift*, 1888, p. 409, under the title of *Die Pathogene Bedingungen der Albuminurie*.

*Nuove contribuzioni sperimentali alla patogenia diserasica o ematogena dell' albuminuria brightica.* *La Riforma Medica*, 1894, vol. iv., p. 338.

In condensing, to the space of a few pages, writings and thoughts that extend over a period of forty years, it may well happen that my exposition will lack the lucidity of the original; for, in whatever tongue Semmola expressed himself, his language was singularly fresh, clear and direct. Therefore, let me entreat the reader to scan these lines attentively, being certain that he has obtained a clear idea of the propositions set forth before drawing his own conclusions therefrom.

Associated with valvular disease of the heart, there is a renal albuminuria that is probably caused by mechanical disturbance of the renal circulation. There are other albuminurias which are clearly due to *nephritis*, as found in gout, syphilis, tubercu-

\* *Bright's Disease of the Kidneys*, New York, 1892, p. 52. Dr. Millard misunderstood Semmola's teaching.

† 1888, vol. i., p. 480, and 1892, vol. i., p. 11. The latter is a fair review of the subject.

losis, lead poisoning and renal calculus. Aside from these conditions, there is a large class of albuminurias which cannot be attributed to any of these causes. They usually present one of the following histories: A man in apparent health has been rejected by an insurance company on account of the presence of albumin in the urine, a fact that hitherto had been unsuspected by him or by his physician. How long he may have been passing albumin in the urine is not known. The duration of life after its discovery cannot be foretold, but the mortality is sufficiently high to prevent an insurance company from risking any money on the life, even though the man appears to be in perfect health in other respects. Or, it may have been a patient who had suffered for some time from an indefinite lassitude or a troublesome indigestion, the urine having been finally examined and the source of the trouble found. The subsequent histories of these cases will be that they will live for a variable period, sometimes ten or twenty years, or even longer; but, if the albuminuria remains uncured, they will sooner or later drift into a condition of positive ill-health. Uræmia, dropsy, pneumonia or cerebral hæmorrhage supervenes, and, after death, the kidneys are found to be in an advanced state of degeneration.

What is the cause of this condition? What are the stages of its development, and at how early a time may it be recognized? Some of the cases commence with an attack of acute nephritis, or acute Bright's disease, and it is supposed that the acute inflammatory process in the kidney is perpetuated in the interstitial tissue after the manner of chronic fibroid pneumonia. But what of the other cases which have no history of acute nephritis? Neither the ancient nor the modern academic pathologist has given us a satisfactory answer to this question. Of all investigators, it seems to me that Semmola has offered us the most probable solution of the problem.

For many years students of Bright's disease have concentrated their attention upon the gross and microscopic condition of the kidney as revealed at the autopsy. Semmola rather studied the patient during life with the aim of detecting the causes which operate *at the commencement of the disease*, rightly thinking that, in the beginning, the disease would be more simple, and would yield its secret more easily than when,

after the lapse of months and years, the appearance of complications and secondary phenomena had confused the clinical picture.

Semmola declared that in the early stage of Bright's disease there are two great clinical facts, namely, a decrease in the amount of urea formed in the body and the appearance of albumin in the urine. That there is an actual diminution in urea-formation will not be denied by physicians who are accustomed to make quantitative analyses in these cases. It is true that the diminished amount of urea passed in twenty-four hours is often carelessly attributed to diminished excretory power of the kidney, but, if this were the case, these patients would have an attack of uræmia every week, because they continue month after month and year after year excreting only one-half to two-thirds of the normal amount of urea. As no evidences of uræmic poisoning develop, it must be admitted that during all these early years of the disease the formation of urea in the organism is greatly diminished. In the later stages, when the kidneys have been seriously damaged, retention of urea is common enough; and when this is the case the symptoms of uræmia are not wanting.

The other great fact about the brightic patient is the presence of albumin in the urine. A whole library of controversy has raged around the question of how the albumin gets into the urine. That it comes from the blood serum is unquestionable, but why does it pass through the kidney-filter into the urine? The dead-house pathologists insist that the blood-albumins never pass through a healthy kidney, and that the presence of albumin in the urine of renal origin always indicates an injury or disease of the renal tissue. Clinicians, studying the living patient, have often come to the conclusion that the presence of albumin in the urine is not always dependent upon actual kidney disease; otherwise, how shall we explain the transient albuminurias that disappear so quickly under milk diet or rest in bed or oxygen inhalations? The albumin must be attributed to some cause more susceptible of rapid changes than a degenerated and inflamed kidney substance. Then, too, if the filtration of the blood-albumins through the kidney is due solely to the damaged state of the kidney tissue, the amount of albumin lost should bear some



constant relation to the intensity and the extent of the kidney disease; but this is notoriously not the fact.

For the presence of albumin in the urine of these cases Semmola has given us a more plausible explanation than the anatomical one. He studied the albuminoids of the blood during life, and found that, in normal blood, there is a small quantity of albumin which diffuses readily through an animal membrane. He found that, in the blood of a brightic patient, the amount of diffusible albumin is greatly increased. He found that these diffusible albumins would pass readily through healthy kidneys, and, moreover, that the passage of these diffusible albumins through a healthy kidney would in a short time produce a nephritis indistinguishable from that of human Bright's disease. Semmola held that, in the early stage of Bright's disease, there is an accumulation in the blood of diffusible albuminoids, and that these albuminoids are excreted by the kidneys because of their presence in excessive amount, just as an excess of bile or glucose in the blood is speedily filtered out by the kidneys. Like bile and glucose, these albuminoids are capable of exciting a nephritis if their passage is long continued. In this manner Semmola transposed the question and asked, not what is the injury to the kidney that permits the filtration of the albumins of the blood, but, rather, which of the blood-albumins is so diffusible that it will filter through any kidney? This is the merit of Semmola's work, that he showed the diseased kidney to be merely a product of the disease, and led us back to the blood-state that had preceded the kidney lesion, that had been silently operating on the kidneys during all the early years of albuminuria, and that finally brought them to the state in which we find them after death. As physicians, it is the process that should interest us, not the product.

Let me now present a series of experiments which confirms the theory above set forth. Having selected a number of healthy dogs, in whose urine no albumin was demonstrable, Semmola painted one-half of the skin of each dog with an impervious varnish and repeated the process daily. During the second week, albumin appeared in the urine. An examination of the animal's blood showed that the amount of easily diffusible albumins was considerably greater than had been found pre-

vicious to the varnishing. That is, the varnishing of the skin had caused the accumulation in the blood of that peculiar, easily diffusible albumin that is found in the brightic blood; and, as in brightic human patients, this albumin passed easily through the kidneys and appeared in the urine.

If a small quantity of blood from a healthy dog was injected into the veins of a second dog, no albumin appeared in the urine; but when the blood of a varnished dog was injected into the veins of a healthy animal, the easily-filterable albumin of the injected blood appeared shortly in the urine.

In the blood of a case of true Bright's disease (due to exposure to damp cold), a great excess of filterable albumins was found. Twelve grammes of this blood were injected into the veins of a healthy dog, and in two hours albumin appeared in the urine. Thirty days afterward, when the patient was fully recovered and the easily diffusible blood-albumin had declined to the normal trace, a repetition of the experiment failed to produce albuminuria.

So much for the presence in brightic blood of a peculiar albuminoid. The varnished dogs not only developed albuminuria, but also an inflammation of the kidney. To determine whether this nephritis was due to a vasomotor disturbance of the kidney transmitted from the injured skin or caused by the imprisoned excretions or by the passage of the albumins through the kidney, Semmola made subcutaneous injections on dogs with solutions of egg-albumin. Not only was the albumin (which, of course, was not assimilable by the tissues) rapidly excreted by the kidney, but the continuous passage of the albumin through the kidney produced a typical nephritis. By killing the animals at different periods in the experiment, it was found that the kidneys bore the passage of the albumin for a short time without injury. At the end of the first week, a marked congestion indicated that the kidneys were beginning to resent the passage of the abnormal substance. During the second week, cloudy swelling of the renal epithelia was present. During the third week, the epithelia of the convoluted tubules had undergone proliferation with fatty and granular degeneration, and patches of small round cells had appeared in the interstitial tissue. The kidneys were swollen, with pale cortex and highly colored medulla; in short, there were all the gross

and microscopic appearances of the large white kidney of true Bright's disease. The urine of the experimental animals contained casts, epithelia and blood-corpuscles corresponding to the different stages of the kidney disorder.

With these experiments, Semmola has paralleled the history of human Bright's disease from the time of the appearance of the diffusible albuminoids in the blood to the stage of advanced disorganization of the kidneys. Some of the animals even developed œdema and albuminuric retinitis. It remains to determine the steps by which the blood of the brightic patient comes to contain this excess of improper and useless albuminoids.

It is known that the albuminoids taken into the body as food must undergo many changes before they are fit for assimilation by the tissues. The gastro-intestinal transformation from albumin to peptone is but the first of a long series of changes by which food is prepared to become flesh; and flesh, in its turn, becomes waste material. One of the most important end-products of this chemical activity is urea, and since urea is the most highly oxidized substance of them all, it is probable that the process of oxidation plays a prominent part in these chemical changes. It is evident that if any influence retards the process of oxidation, less urea will be formed; and, at the same time, those substances which should be converted into urea will accumulate in the body. Semmola claimed that this is exactly the case in the early stage of Bright's disease with its deficient formation of urea and its excess of abnormal albuminoids in the blood. To his mind, the excretion of this excess of albuminoids by the kidneys was simply an act of depuration, of which we have many analogues.

Semmola believed that the deficient chemical activity of early Bright's disease is due to an interference with the respiratory functions of the skin. Recalling the fact that by varnishing a large portion of the skin of dogs, we can cause a rapid accumulation of these albuminoids in the blood and set in motion the train of events that leads to a typical brightic kidney, the proposition seems tenable.

From the time of Bright himself, in 1827, until the present, every observer has noticed the frequency with which cases of acute and chronic Bright's disease are caused by the action of



cold and dampness upon the skin; but the chain of events which connects the gradual action of damp cold upon the skin with acute and chronic inflammation of the kidney, has never been so plausibly presented as by this Italian observer. Here, then, is Semmola's complete picture of the development of Bright's disease as described by him in a paper presented to the Amsterdam International Congress in 1879:

*a.* The gradual action of damp cold upon the skin.

*b.* A progressive defect even to abolition of the respiratory functions of the skin, with the following effects:

1. Cutaneous anæmia.
2. Accumulation of excrementitious cutaneous products in the blood.
3. Alteration of the albuminoids coming from the food as peptones.
4. Diminution in the combustion of albuminoids and, in consequence, in the production of urea.

The consequences of these changes upon the kidneys are as follows:

1. Renal hyperæmia (augmentation of pressure).
2. Irritating effect of this hyperæmia because of the excrementitious matters in the blood.
3. Elimination of albumin by the kidneys, because those unchanged albuminoids (unchanged because of the functional failure of the skin) are unfit for nutrition and useless to the body.
4. Progressive diminution in excretion of urea on account of diminished production.

There now develops another series of events:

1. General failure of nutrition, caused by the defective elaboration of the blood-albumins.
2. Inflammation of both kidneys, due to the persistent passage of albumin. The kidney inflammation, in its turn, still further reduces the amount of urea in the urine by retarding its excretion, and increases the loss of albumin by the addition of a true renal albuminuria to the preceding hæmatogenous loss.

Bear in mind that this description applies only to that form of albuminuria which is caused by influences affecting the skin. Cardiac, gouty, syphilitic and tubercular nephrites have their own laws of development; neither the excess of diffusible albuminoids nor the early and invariable decrease of urea is found in them.

Semmola has recalled and verified an interesting observation. In the class of patients under consideration albumin has been found in the perspiration, saliva, bile and fæces as well as in the urine. This statement has been confirmed by Profs. Brancaccio and Arena of the University of Naples. The presence of albumin in the fæces of brightic patients was known forty years ago, for Jaccoud refers to it in a note in his translation of

Graves's Clinical Lectures. In health these excretions never contain albumin, nor can its presence be explained as a result of a local kidney disease. On the other hand, the simultaneous presence of a diffusible albumin in all the excretions points with certainty to the presence of this substance in the blood.

Another point in favor of Semmola's theory is the remarkable effect of inhalations of oxygen in diminishing albumin in the urine. By Semmola's theory we readily understand the action of the oxygen in transforming the imperfectly elaborated albuminoids into urea or other products; while, if we regard the nephritis as the sole cause of the albuminuria, this action is unintelligible; for it is impossible to believe that a few inhalations of oxygen will, in the course of a few days, heal a chronically diseased kidney so thoroughly that no more albumin can leak through.

In presenting the treatment that Semmola claimed to employ with considerable success, I cannot do better than translate his own summary as presented to the French Academy of Medicine in 1886.

"1. Exclusive milk diet for a long time. After the albumin has disappeared, permit a gradual return to meat and yolk of egg.

"2. Frequent, regular, dry frictions of the skin, frequent sweat-baths, massage and douche. Use no cold water, as the least impression of cold upon the skin may aggravate the disease.

"3. Order the invalid to live in a mild, dry, equable climate. In variable climates, in winter, the brightic patient should be kept continually indoors, because the skin surface is exquisitely sensitive to atmospheric changes. The neglect of this precaution is the cause of many failures to cure.

"4. The administration of the iodide and chloride of sodium in increasing doses to tolerance.

"5. If, after two or three weeks, the albumin has not disappeared from the urine, especially when dropsy has disappeared, substitute for the iodide of soda either sodium phosphate or small repeated doses of the hypophosphite of lime or of soda, up to a dose of three or even four grammes daily. These salts favor the assimilation of albuminoids."

[These drugs, especially the sodium phosphate, must be used with caution. Semmola evidently had not read *Fleischer's*

report on the effect of sodium phosphate on nephritic patients,\* nor of the dog that was poisoned, nor of the inability of the inflamed kidney to eliminate the salts of phosphorus.—G. F. L.]

“6. Methodical inhalations of oxygen. Recommended since 1867.

“7. Avoid astringents not only as useless but also as harmful. Gallic acid has been abandoned. If iron does have an astringent effect, such action on the cutaneous capillaries would be undesirable.”

In conclusion I would say that while Semmola has placed the doctrine of the hæmatogenous origin of Bright's disease in its most convincing form, the same idea has been expressed by other clinicians. In the *London Lancet* of 1849 (vol. ii., p. 29), just one year before Semmola's first publication in Italy, there appeared a remarkable clinical lecture by Prof. Walshe, the newly-elected Professor of Practice of Medicine in the London University College Hospital. The lecture is entitled “Bright's Disease not Essentially a Renal Disease but Essentially and Primarily a Blood Disease.” From clinical facts Dr. Walshe argues very ingeniously that the first step in Bright's disease is a blood-degeneration, that the disease of the kidney follows and is caused by the degenerated state of the blood, and that the primary blood-changes are “probably the result of errors in the primary or secondary digestive function.” I mention this lecture because Semmola repeatedly claimed to be the only known physician who, in 1850 and the following years, understood and advocated the doctrine of the hæmatogenous origin of Bright's disease. He was evidently ignorant of the shrewd conjecture of his great English contemporary.

Similar views were held by Graves, Elliottson and other English physicians of the time. In a further communication I hope to review the teachings of these early observers, together with the little-known work of the late Dr. Mahomed on what he termed “the pre-albuminuric stage of Bright's disease.” Thanking you for the generous amount of space that you have granted for this letter, and with best wishes for the continued success of your journal,

Yours cordially,

GEORGE FREDERICK LAIDLAW.

137 WEST 41ST STREET, New York.

\* *Deutsche Archiv für Klinische Medicin*, 1881, xxix., p. 129. See also my own studies on the excretion of phosphates in the urine of Bright's disease in the *New York Medical Record*, 1898.



## THREE CASES OF BLADDER TUMOR.

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

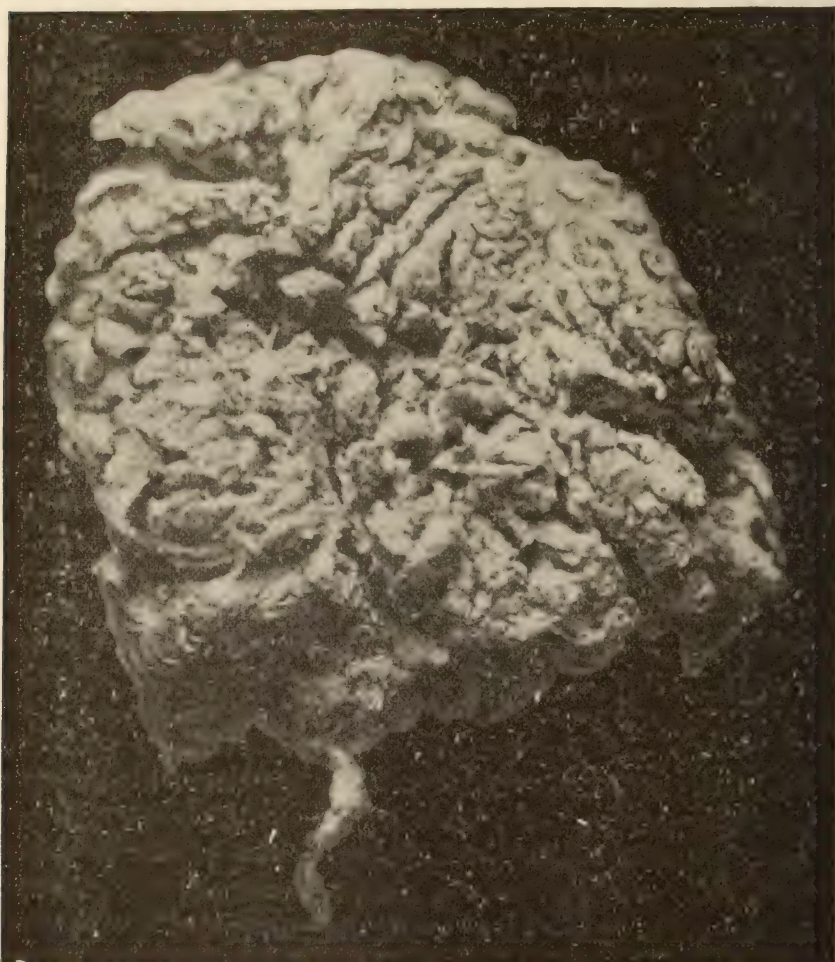
(Read before the Homœopathic Medical Society, State of Pennsylvania, Pittsburgh, Sept., 1898.)

THE literature of vesical neoplasms is sufficiently scanty to warrant any and many additions to the subject; and this is particularly true of clinical cases, as our present data are still too largely based on museum specimens removed or even discovered post-mortem. With this apology, I beg to present to you the records of three unusual and yet in many respects characteristic cases of bladder tumor selected from among those that have come under my observation.

CASE I.—Male, 60 years of age, operated March 29, 1896, with Dr. Charles M. Thomas, had been subject to attacks of hæmaturia for fifteen years. These lacked regularity or apparent exciting cause, although occasionally following the exertion of a shooting-tramp; one of the severest appeared during sleep. The hæmorrhages came on suddenly and ceased in like manner, the blood being bright red in character, and, when decreasing in quantity, being noticed particularly at the close of urination. For some time past there had been but little bleeding, and that at long intervals. Twelve years previously I had examined some shreds he had passed, which evidently came from a typical papilloma. The tufts were covered with a single layer of cylindrical epithelium and contained a capillary loop, supported by a delicate network of connective tissue. At no other time had any shreds been found. Except when the bladder was distended with blood, he had been free from pain throughout the course of the disease, and between hæmorrhages was apparently in the best of health. The same was true of the frequency of urination. Repeated examinations of the urine showed no signs of cystitis or kidney mischief.

For a few days before I saw him he had been suffering from bleeding of varying degree, as on many previous occasions, but this became so profuse on the morning of operation as to fill the b'adder with clots and produce retention. Attempts at

evacuation by means of the catheter and syringe, the lithotripsy pump and evacuator, were unavailing. The bladder was distended until it reached the umbilicus, and the condition was naturally associated with the characteristic straining and agonizing pain dependent upon such an unrelieved retention and



distention. To make matters worse, he showed the effects of loss of blood to a striking degree: a most profound anæmia, air-hunger, cold extremities, pinched face, etc., etc,

Epicystotomy was at once done, and when the bladder was emptied of clots a large cauliflower growth was found spring-

ing from its left-hand wall, in what Fenwick terms the "middle zone." (The accompanying photograph shows about the natural size of the tumor after two years' preservation in alcohol, but when spread out in the bladder, with its floating papillæ, it was nearly as large as my fist). Fortunately it was pedunculated, the pedicle resembling the last two phalanges of a finger, one side of which was attached to the bladder-wall and the other to the growth; in other words, its base can be roughly stated as two inches by  $\frac{3}{4}$  of an inch, and its length as a little less than an inch. It could thus be grasped almost in its entirety by an angular ovariotomy clamp, which was left in position, the oozing from the portion not included being controlled, after a thorough douching with hot water, by iodoform gauze, arranged like the *handkerchief pelvic-pack* of Miculicz. In this way the duration of the operation was so lessened that the patient was gotten to bed alive. Extensive or elaborate manipulations would, besides, have been impossible, for the operation was an emergency one, performed at dusk, in an improvised Trendelenburg position, with none of the indispensable accessories for such work.

The pack was removed on the second day on account of persistent vomiting, the clamp on the fourth, when the nausea disappeared, and an overlooked piece of gauze was expelled at the end of the first week. No tubes were used, but the bladder was irrigated several times daily through the urethra, which was unusually tolerant. The supra-pubic fistula did not completely close for two months, healing being delayed by incrustation of phosphates.

This phosphatic deposit in the supra-pubic fistula has been with me a frequent and annoying, or rather delaying, complication. In a number of epicystotomies, particularly in the presence of an alkaline, catarrhal urine, they have been almost as tenacious as the slough of a hot-water-bag burn. Applications of weak muriatic or nitric acid, or dilute bladder-washings with the same, have proved more satisfactory in my hands than anything else. In one stone case, not seen during the after-treatment, I was called some weeks later by the attendant to find and remove a large *præ-vesical* calculus; the inlying catheter had been allowed to slip out of the bladder, and the industrious washings had developed an enormous *carum Retzi*,



lined with phosphatic incrustations, and ultimately filled with a solid mass of the same character.

Since the healing of the supra-pubic wound he has enjoyed excellent health, the urine being free from albumin, pus, blood, epithelia, or casts, and the bladder emptying itself completely. The cicatrix is firm and close, showing no sign of giving away at any point. Thirty months of freedom from all symptoms, objective and subjective, should give us a fairly safe prognosis against recurrence, and particularly against a malignant degeneration—a possibility sufficiently frequent to deserve consideration.

This case certainly presents the classical features of vesical papilloma. Nothing could be more characteristic than the repeated hæmorrhages, the first and practically only indication of cystic trouble during fifteen years; their onset and cessation, sudden and without apparent cause, and their recurrence and duration equally uncertain; the blood at times bright red and at others clotted, when scanty appearing at the end of urination, when profuse distending the bladder with clots and producing retention; the amount varying without any relation to the size of the growth, the severest hæmorrhages having occurred, the one quite early and the other just before removal. The pathognomonic symptom was, of course, found in the papillary tufts demonstrated by the microscope, and the importance of a most careful watch and the sieving of everything passed is shown by the fact that such evidence was found but once. Pain in such cases depends upon the development of a cystitis, as well as upon the proximity of the tumor to the vesical neck. Fortunately, this one sprang from the lateral middle zone, an unusual location, but with a cauliflower growth of such unusual size it is remarkable that portions of it did not press upon this region, or even obstruct the flow of urine. The absence of cystitis is surprising, as a bladder containing a tumor is peculiarly susceptible to infection, and catarrh is almost constant with large tumors. This freedom must be laid at the door of clean catheterism, which had much to do, therefore, with the unusually long existence of the disease and the prevention of a fatal issue.

CASE II.—Female, single, 25 years old, patient of Dr. Cook, of Harrisburg; first seen May 27, 1895.

She presented the history and symptoms of a progressive and pronounced calculus cystitis, which had existed for about two years, and for which she had been under treatment for nearly half that time. Urination was so frequent as to be practically constant, and, in fact, it was hard to get her off the *commode* long enough to take the history and symptoms. Pain, too, was a prominent symptom, not only local, but reflected, as is generally the case, to the back, hypogastrium, down the thighs, etc. It was worse, of course, after the expulsion of a few drops of urine, and was associated with the most violent tenesmus and straining. The bladder was tender, contracted and so much thickened as to very naturally lead to a previous diagnosis of malignancy. From time to time she had passed calculous pieces and phosphatic *débris*, in connection with which she described a peculiar symptom: She felt something drop into the bladder, immediately after which there was an accession of pain, tenesmus, etc., lasting until one or several calculous bits were passed, a few minutes later. As we found out subsequently, this sensation must have been produced by the detachment of incrustations, not, as she supposed, by the dropping of foreign bodies into the bladder from the ureters. The urine was characteristic of an old cystitis, alkaline, and foul-smelling, containing triple phosphate crystals, pus-cells, a few blood corpuscles, and quantities of stringy mucus. Its constant contact with the external genitalia had produced a vulvitis, with discharge and inflammatory thickening. Hæmaturia had been an inconstant and only an early symptom, and at no time had amounted to more than a few drops of bright red blood or an occasional clot.

Under chloroform the urethra was dilated and the bladder explored with the finger. Five sessile tumors were felt, each one being covered with phosphatic incrustations, about the size of a dime, and raised about a quarter of an inch from the surface of the surrounding mucous membrane. They were located near the ureteral orifices, in the trigone close to the urethral opening, and the remaining two on the right side of the bladder, a little higher up. The walls were so hard and inelastic that there was practically no vesical cavity. The presence of the tumors was corroborated by the use of Kelly's cystoscope, and the attempt made through the

tube to scrape off one of them with a sharp spoon. While the removal of the incrustation produced no bleeding, the curretting of the growth caused such a severe hæmorrhage that we were obliged to desist.

Four days later the bladder was opened above the pubes by Trendelenburg's transverse incision, the patient being in the position suggested by the same surgeon. After the viscus was found the opening was enlarged by a vertical cut. The edges of the cystic wound were drawn up with guy-threads, and Fenwick's *caisson*, supplemented by Watson's speculum, proving unsatisfactory, the cavity was practically turned inside out by a finger in the vagina. This made it very easy to dissect off the growths, leisurely and accurately, with curved scissors and tissue forceps. The resulting oozing was readily controlled by means of Keyes's *handkerchief* of iodoform gauze, packed full with strips of the same material, the former being drawn against the urethral orifice, with a string tied to its centre, and brought out through the meatus. A couple of days later the gauze-pack was removed and two syphoning-catheters introduced.

Recovery was naturally tedious, the cystitis gradually subsiding under the supra-pubic drainage, which was kept up for nearly four months, and under persistent bladder washings. All the symptoms disappeared, with the exception of the frequent urination, dependent upon the thick, unyielding vesical walls. After long-continued distention by flushing, this has finally yielded to such a degree that she wrote me a few days since, saying she could "go very comfortably six and often seven hours between urinations." In other respects her local and general condition is perfectly satisfactory, so that after more than three years we are warranted in assuming that there has been no recurrence, and that she is not only cured of her tumors, but of the consequent bladder catarrh and its cicatricial and contractile results. As is apt to be the case with the transverse incision, particularly when it has to be kept open for a long period of time, a small hernia has developed above the pubes, but it is readily controlled by a truss.

I was led to use this incision because the bladder was non-distensible, and because of Trendelenburg's success with it in vesico-vaginal fistula, a condition producing a similar vesical



contraction, and requiring unusually good access to the cystic cavity for its correction. The eversion of the mucous membrane by pressure from the vagina was of invaluable service, and I believe deserves a trial in such cases.

The tumors were sessile papillomata, with closely grouped but quite characteristic villi, and their homologous nature was readily appreciated, as they were trimmed off with the mucous membrane alone, showing no infiltration of the subjacent tissues. The hard, brawny bladder-wall was very suggestive of the induration supposed to be pathognomonic of cystic cancer. Had it not been for their distinct multiplicity, which points to papilloma, their sessile form and phosphatic coating would have strengthened the suspicion. The pain, too, while evidently dependent upon the cystitis, was far more severe than any I have seen with an ordinary catarrh, or even with stone. She was young for carcinoma, and, for that matter, even for papilloma; but sarcoma not infrequently occurs in the young as multiple, sessile or polypoid tumors, and the villous tendency of all bladder growths is familiar to every one. The practical absence of hæmaturia is noteworthy, particularly in papilloma, which, at some time during its course, is supposed to produce hæmorrhage much more persistent and free than either cystitis or calculus.

CASE III.—Male; 69 years; under observation from April, 1893, until November, 1895. Consultants, Drs. Charles M. Thomas, W. C. Goodno, John E. James and J. Nicholas Mitchell.

The patient had noticed for some time gradually intensifying symptoms, which could be readily attributed to vesical calculus or to bladder catarrh associated with prostatic enlargement and irritation. He urinated with increasing frequency, both by day and night, but especially when moving about or driving. The uneasiness at the close of the act had gradually become a distressing "never-get-done" tenesmus. Pain was present at the same time, and was both local, over the pubes, in the hypogastrium, perinæum and rectum, and reflected to the back, meatus, scrotum, down the inner side of the thighs, etc. While felt all the time, it was particularly aggravated by motion and at the close of urination. The associated tenderness of the perinæum necessitated the use of

an air-cushion. The urinary stream was occasionally interrupted, and was thrown with diminished force. A couple of ounces of residual urine remaining in the bladder was found to be slightly alkaline, and showed the usual signs of beginning catarrh. Blood had been noted early, but in very small quantities and at the close of urination.

A careful sounding gave the characteristic stone click after considerable difficulty, and when the beak of the instrument was reversed, in what seemed to be the post-prostatic pouch, the manipulation being aided by rectal touch. The whole urethra was exquisitely tender, to a very unusual degree, in fact, and this, of course, was particularly the case when the deep portion was entered.

The stone was evidently small, but epicystotomy was decided on, because the perinæum was deep, the subject being corpulent, and because the lateral prostatic lobes were sufficiently enlarged to preclude satisfactory digital exploration. The high cut was accordingly made at one sitting, in the Trendelenburg position, aided by the Petersen bag (Braun's colpeurynter being used), together with moderate distention of the bladder with fluid and air.

A point noted in this case, which I have since made frequent use of, may be worthy of mention: in corpulent persons there is often a crease just above the pubes and groin which can be utilized by raising the pendulous abdomen to get *directly* at the bladder or even a hernia. I should also add that for several years I have dispensed with Petersen's rectal bag, and even with vesical distention with fluid, relying on what might be aptly termed "the Sim's position of the pelvis," supplanted, if necessary, by Dittel's inflation of the bladder with air. It may be needless to add that Senn's *two-tempo* epicystotomy is my routine practice, and this plan has stamped out the bugbear of urinary infiltration in the præ-vesical space—in fact, it has, so far, done away with any mortality.

On opening the bladder the lateral prostatic lobes were found to be moderately enlarged, while the trigonal depression was but slight. What seemed to be a valvular middle lobe projected backward as a small tumor about the size of the terminal thumb phalanx. This flap, a little more pedunculated than those we so frequently have occasion to bite or trim

off with such marked relief of obstructive symptoms, was enclosed in a perfect egg-shell of phosphatic salts. The shell broke readily and was as easily picked off as its contents and the pedicle, leaving a perfectly smooth interlobar surface.

While this was, strictly speaking, not a tumor of the bladder, springing in reality from the prostate, yet in its clinical signs and effects it was so clearly cystic that I have included the case and do not believe any distinction necessary. The histological examination of the growth was unsatisfactory, sections being submitted to several examiners whose opinions were widely at variance. Thus it was regarded by some as a middle-lobe hypertrophy, infiltrated with inflammatory cells, and by others as a round- and spindle-celled sarcoma.

The patient recovered without a hitch and was soon at his business again, quite free from any bladder symptoms. Some eighteen months later the urinary frequency, and particularly the pain, began to creep back again, and he gradually failed in health and lost weight. This went on through the winter of '94-'95 until the one prominent complaint was agonizing, almost constant pain, local and radiating, but pointing particularly to the bladder neck. Careful sounding found no stone, and the catheter drew but a couple of ounces of residual urine, which was only moderately catarrhal. Rectal examination showed some increased prostatic enlargement and a suspicious brawny hardness. This, with his age, naturally suggested carcinoma. Finally, two years after the first operation, the bladder was again opened through the old cicatrix, under cocaine, for relief of the urinary distress by drainage. Palpation of the vesical cavity was practically negative, the lateral prostatic lobes being rather more, but evenly and smoothly enlarged. The remaining six months of his life was pitiable, death resulting from exhaustion and pain—pain of every character and in every location: bladder, perinæum, scrotum, penis, back, limbs, chest, etc. At no time was there any further bleeding.

The autopsy showed round-celled sarcoma, confined entirely to the prostate, moderately enlarged, sarcomatous, iliac, abdominal and bronchial glands, and small, secondary deposits in the lungs, liver and kidneys. While there was some doubt as to the character of the trouble after the first operation, when



the symptoms recurred the pain of malignancy was such as never to be forgotten by those who watched the case. This was particularly noticeable, as there was no cystitis, its common cause in bladder growths. It is unusual to find a sarcoma of such long standing confined strictly to the prostate, although cases have been recorded of probably even greater capsular distention. This is especially surprising when we remember that the first manifestation was a prostatic offshoot, the removal of which must have opened any overlying capsule. Such tumors spread, as a rule, by infiltrating the bladder-walls, urethra, etc., the peri-cystic tissues, even involving the pelvic bones, and finally disseminate themselves through the circulation. Instead of this the metastatic path was along the lymph-channels, as in carcinoma, and occasionally in round-celled sarcoma, notably in the breast. This course, together with the integrity of the capsule, may account for the slow glandular and visceral infection, no metastases of any size being found. Bladder carcinoma runs a typically slow and local course on account of the remarkable paucity of the lymphatic drainage. These vessels are more abundant and in closer proximity with the mucous membrane about the trigone, while the prostatic supply is even greater. In consequence, carcinomatous diffusion from the latter source is occasionally both rapid and widespread, but this seems to be more particularly the case with soft, so-called encephaloid growths which have first soaked through the capsule and infiltrated adjoining structures.

---

DESTRUCTION OF INFECTION BY ELECTRO-STERILIZATION.—Dr. J. Mount Bleyer, in a paper read before the Medico-Legal Society, advocates that all parts to be examined by the X-rays be prepared as if for surgical operation, to prevent inoculation. The static machine is recommended instead of the Ruhmkorff coil. The current from the former, on account of its high voltage and low amperage, has not the property of carrying foreign material into the depths of the tissues as readily as the other current. When infection has once occurred, he advocates an original method of sterilization, which is also applicable to other infections. Wounds must be drained and all pus removed, and the parts to be sterilized placed in a salty solution of distilled water, connecting with the negative pole of a galvanic battery. The positive pole may be placed on any convenient part of the subject. A five mil-ampere current for each square inch to be sterilized should be used for half an hour; after that the polarity should be reversed for five or ten minutes to set free the chlorine, which will react on all the external and internal exposed surfaces. Clean surgical dressings should afterward be applied. This method of treatment may also be applied to the stings of insects, dog bites, and the wounds of venomous serpents.—*Medical Times*, August, 1898.

## IODINE IN PNEUMONIA.

BY W. T. LAIRD, M.D., WATERTOWN, N. Y.

(Read before the Medico-Chirurgical Society of Central New York.)

IN the six volumes of Raue's *Record*, containing the published experience of the whole homœopathic profession from 1870 to 1875, iodine is not mentioned as a remedy for pneumonia. Jahr, in his *Forty Years' Practice*, entirely ignores it in the treatment of this disease. Raue and Arndt, in their respective works on *Practice*, dismiss it in a few lines, merely saying that it has been recommended by Kafka "at the beginning, when the disease localizes itself."

Bæhr speaks of it as a remedy of minor importance in the early stages, but says it "may be prescribed with great propriety" in the third stage "if the suppurative process goes on without any marked febrile symptoms, assuming rather the form of a slowly progressive hectic condition, confined entirely to the lungs," but gives the preference, when these symptoms are present, to sulphur and hepar sulph.

Lilienthal advises it in croupous pneumonia, with "sensation of weakness in the chest, with anxiety and oppression, and burning, tearing, stabbing pains . . . dyspnœa and blood-streaked expectoration;" and also quotes approvingly the indications given by Bæhr for its use in the third stage.

Farrington gives the following accurate indications: "It is especially useful . . . when the plastic exudation commences. There is decided cough, with great dyspnœa; difficulty in breathing, as though the chest would not expand, and blood-streaked sputum. You will find some portions of the lung beginning to solidify. You may also give it later in the disease, after the stage of hepatization, in the stage of resolution, when, instead of absorption and expectoration of the exudate, slow suppuration appears, with hectic fever and emaciation; the patient feels better in the cool, open air than he does in the warm room."

Dewey, in his *Quiz Compend*, recommends it in the "first and second stages, especially in the croupous form, where the

hepatization tends to extend rapidly; difficulty in breathing, as if the chest would not expand; cough and blood-streaked sputa, accompanied by high fever."

Goodno, in his recently published work, mentions it approvingly, but gives no indications.

It will be seen from these quotations that all of our medical authorities, with the exception of Bæhr, recommend iodine in the first stage of pneumonia, when the onset is sudden and violent. I have never used it in this stage, for in all cases characterized by high fever and rapid hepatization in the beginning *verat. vir.* has done so well that other remedies have not been required. My experience has been confined entirely to its use in the second and third stages. Here it occupies a field peculiarly its own. The "keynotes" are tardy resolution and deficient vital reaction.

You will rarely find iodine indicated in the second stage before the beginning or middle of the second week. Up to this time the case may have been progressing favorably, but the improvement stops, and the usual remedies fail to afford relief. The only subjective symptoms worthy of mention are intolerance of heat and relief in the open air, and these are not always present. In fact, the absence of all characteristic subjective symptoms is a strong indication for the use of the drug. The cough may be dry or loose, slight or severe; the temperature rarely rises above  $103^{\circ}$ , and is usually  $1^{\circ}$  or  $2^{\circ}$  lower; but the case drags on day after day, and week after week, the lungs remain hepatized, with no tendency to resolution, and the patient steadily loses flesh and strength. Now put ten drops of the tincture of iodine in three ounces of water, keep the glass covered with oiled paper to prevent evaporation, give a dessertspoonful of the mixture every one, two or three hours, according to the urgency of the symptoms, and you will be surprised and gratified at the rapidity of the cure.

You will find iodine even more valuable in the third stage, when resolution is long delayed, and the fever assumes a hectic type, with severe chills, sudden and excessive variations of temperature, and profuse sweats.

The more imminent the danger of suppuration, or the more closely the case approaches the border line between pneumonia



and phthisis, the more surely is iodine indicated. In many instances it is the only medicine that can arrest the downward progress and save the patient.

The following cases illustrate the value of this important but neglected remedy:

Frank G. was seen, in consultation with another physician, May 9, 1893. He had been suffering from catarrhal pneumonia nearly a month, and, although the acute symptoms had subsided, the lung still remained hepatized. He was losing strength, and had an irregular fever, with occasional sweating spells. Iodine was prescribed, and he made a rapid and uninterrupted recovery.

Mrs. H. contracted croupous pneumonia in the summer of 1894, while visiting friends in Vermont. The attack was a severe one, and it was fully three months before she was able to come home. She consulted me soon after her return, complaining of weakness and a feeling of general malaise. Slight exertion caused palpitation of the heart, dyspnoea and profuse perspiration. She felt worse in a warm room and better in the open air. The lower third of the left lung was still hepatized. Iodine caused resolution in two weeks, and chin. arsen. completed the cure.

Roy B., a rather delicate boy, ten years old, was attacked with whooping-cough about the 1st of March, 1893. Some three weeks later an imprudent exposure brought on catarrhal pneumonia. Under *verat. vir.*, followed by *bryonia*, the disease pursued the usual course, and by the 1st of April the patient seemed to be convalescing, when he took cold and had a relapse. He again improved slowly under the usual remedies until April 15th, when the furnace fire accidentally went out during the night. He awoke in the morning thoroughly chilled, and had a second relapse. This time he did not rally, but steadily grew worse. At the end of the fifth week of the disease one-third of the left lung was still hepatized, and there were also scattered patches of consolidation in the right lung. The cough was slight and expectoration scanty. The sputum, examined under the microscope, showed mucous corpuscles, broken-down lung tissue undergoing fatty degeneration, and a few Koch's bacilli; but no pus could be detected. Every morning he had a chill, followed by high fever, the temperature, which was 96° at the beginning of the chill, rising to 105°, 105.5°, and on one occasion to 106°. This, in turn, was succeeded by profuse perspiration, during

which the temperature gradually fell until it again reached  $96^{\circ}$ , about 9 or 10 P.M., when the cycle of chill, fever and sweat was repeated, and lasted through the night. Sulphur, hepar sulph. and sanguinaria were given without effect. Another physician was now called in consultation, and at his suggestion calc. phos., and afterwards calc. carb., was tried, but with equally unsatisfactory results. At the end of the sixth week the patient was in a critical condition, and was slowly but surely losing ground. Iodine was now prescribed, ten drops of the tincture in a glassful of water, a teaspoonful every hour. Two days later he had only one chill during the twenty-four hours, and the range of temperature was reduced one-half, the maximum being  $100^{\circ}$  and the minimum  $97^{\circ}$ . The medicine was now given every two hours. In three days more the chills, fever and sweat disappeared, resolution commenced, and just twelve days after the first dose of iodine was administered the boy was discharged cured.

I have now used the remedy successfully in nearly thirty cases of this disease. My experience fully sustains Prof. Goodno's claim that it occupies "a position in the front rank of medicines for pneumonia."

---

#### SODIUM BICARBONATE SOLUTION AS A SURGICAL DRESSING.

BY BERTRAND K. WILBUR, M.D., SITKA, ALASKA.

(Read before the Homœopathic Medical Society, State of Pa., Pittsburgh, September, 1898.)

JUST as the most of life is made up of little events, so the majority of cases coming to every physician and surgeon are those of the minor ills. To relieve these quickly and well is a large part of our professional work; and among these minor ills none is more common, nor, for the size of its lesion, causes more real agony, than the abscess.

It would be but to multiply words to speak of the etiology, pathology and treatment in general of this disease. Those of us who have handled the knife must honestly confess a considerable degree of skepticism in medical treatment. In earlier days, as we came forth from college, we gave the potencies of belladonna, pulsatilla and hepar, and also the crude drugs, yet we find the knife the best of all remedies. Perhaps

some do cure a sac containing 30 c.c. of pus with these or other remedies, but *we* do not.

The filthy poultice, that incubator for bacteria, with its rotting effect on diseased and well tissues, we condemn. True, it affords some relief, but the knife affords greater. Those of us who have seen a case of felon, sent to us by some well-meaning but deluded confrère after three or four weeks of bread-poulticing and flaxseed maceration, will scarcely listen to the advocates of this instrument of prolonged torture. With early free incision we are familiar; nor are we apt to forget the apparent paradox, the freer the incision the quicker the healing.

It is to the treatment of abscess *following* operative measures that I desire to call your attention, and to that end I append a few illustrative cases. Once freely incised, drained thoroughly and dressed antiseptically, healing usually progresses with a remarkable degree of rapidity. But a certain class of cases, and by no means a small proportion, do not granulate rapidly or kindly. In spite of free openings and apparently perfect drainage, suppuration continues. Bichloride of mercury, carbolic acid, hydrozone, iodoform, or any of the old faithfuls, do not check the process, nor do the tissues react. In short, the process of repair is lazy and more or less pain persists. In such cases especially, and, indeed, since I have tried it, in every case of abscess following incision, a 2 per cent. solution of sodium bicarbonate has proven most excellent.

A short article in the *Medical and Surgical Reporter* of Philadelphia first directed my attention to this chemical as a dressing in phlegmonous inflammations, it being recommended by a Russian army surgeon. It is best applied as follows: After free incision, with ordinary antiseptic precautions, the wound is lightly packed and covered with plain gauze saturated with a 2 per cent. solution of sodium bicarbonate. Over this cotton is placed, and the whole covered by oiled muslin. This oiled muslin is used to prevent evaporation, and is not to retain heat especially, and, contrary to most impervious dressings, there seems to be but slight tendency to rot or macerate the tissues. The dressing is changed at varying intervals, according to the amount of discharge; but it should be remembered that with this application fewer dressings are required. The



results are remarkable in the rapid subsidence of suppuration, and the bright, firm granulations that rapidly close the wounds. From this description the process of cure seems to be attained so quickly and smoothly that one might readily doubt its verification. It is not theoretical, however, for a series of cases have yielded uniformly good results, as the three selected ones following will illustrate.

John N., æt. 5 years, acute abscess of hand at base of third finger; pain, redness and swelling of palm and dorsal surface, as well as of all of third finger and bases of other fingers; incision, with evacuation of 5 c.c. of pus. Applied sodium bicarb., as above. Swelling disappeared within twenty-four hours; complete healing in eight days under three dressings. This is cited as a typical case, though the healing is even more rapid in some.

The second case is typical of the infected wound class, with extending inflammation of adjoining tissues.

No. 2. Fred M., æt. 23. Small scratch on third finger of left hand; infected a week after patient received it; redness of lymphatics; swelling of arm and forearm to twice their normal size; exploratory incision of arm and forearm, and sloughs trimmed away from wound of finger; no pus. Dressed entire arm with sodium bicarbonate. Pain, redness and swelling rapidly subsided and infected wound healed.

In the next case the sod. bicarb. was used experimentally, to observe its effect in allaying inflammation of the skin from any cause and where pus was not present.

No. 3. Mrs. C., æt. 58. Contusion on external surface of leg, half-way between knee and ankle, caused by a hard blow. Much pain and redness, with great tenderness, persisting for a month. Bichloride compress, arnica lotion, liniment of soap. Anodyne liniment was tried unsuccessfully. The first application of sodium bicarb. on gauze under cotton and oiled muslin, as previously referred to, markedly reduced all inflammatory symptoms, and its continued use for a week returned the parts to their normal condition, except as to tenderness and partial loss of function, which persisted some time longer.

These three selected cases, being verified by others, stand as types of three important uses of this solution. To review in brief:

Sodium bicarbonate in a 2 per cent. solution on plain gauze is an ideal dressing for acute abscesses that have been drained.

In cellulitis and phlegmonous inflammations of any character its effect is prompt in affording relief and subduing inflammation.

In any active, superficial inflammation from any cause, recent or remote, it may be used advantageously.

It has also proven valuable as a local stimulant in lazy ulcerations or sinuses.

In closing, these marked actions on the skin and cellular tissues suggest the possibilities of this solution in erysipelas—a possibility so full of hope that it is well worth the trial.

---

#### THE BAD NAUHEIM (SCHOTT) TREATMENT OF HEART DISEASE AT HOME.

BY EDWARD R. SNADER, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Pittsburgh, Sept., 1898.)

THE Schott method of treating chronic cardiac disease, and the astonishing effects occasionally resulting from pursuing the course of treatment originated and carried out by the Schotts at Bad Nauheim, Germany, have naturally created in the medical world a desire to know the particulars of the treatment in detail. Not every one can journey to Bad Nauheim, and few, even were they actually on the ground, would, for very obvious reasons (all the patients being private and all the physicians busy), be able to penetrate the charmed circle, where facilities for exact study, observation and investigation sufficient to give one a true idea of the workings of the method would be afforded.

During my investigations at Bad Nauheim I was most fortunate in the friendship of a number of physicians, who, appreciating my mission, lent me every facility in their power to forward my work.

This paper is the second of a series I shall present to the profession in which I shall endeavor to disclose what I learned at Bad Nauheim.

In view of the fact that but few patients are able, by reason of the stage of their disease, to take an ocean trip, a long railway ride, nor possibly afford the expenses of living, of baths, of exercises, of physicians, at Bad Nauheim, not to mention the difficulties of a foreign tongue and a German cuisine, any knowledge that will make it possible to carry out the Schott method at home will, I am sure, be welcome to the profession.

Aside from the influence of change of scene, a regulated diet and strange food, absence from business, freedom from domestic cares, a favorable climate, and mineral drinking-waters, the principal means by which Bad Nauheim achieves its results are, briefly, by mineral baths and exercises.

#### THE BATHS.

The baths are the simple saline, the thermal brine, the sprudel, the sprudel current.

The simple saline bath is infrequently employed in heart affections. The water for this bath comes from the springs known as the Grosser Sprudel (No. 7) and the Freiderich Wilhelm's Quelle (No. 12), as it does for all the other baths. The simple saline, while not much employed, in the process of making is productive of certain salts that are of great value for regulating the mineral strength of the other baths. By evaporating the water from either or both of the springs the natural carbonic acid gas characteristic of the waters is allowed to escape, and the heavier salts are permitted to subside. In the process of evaporation, and with subsequent boiling, and after much of the salt has been abstracted (they manufacture salt at Bad Nauheim), there is left a thick, dark, muddy-looking, New Orleans molasses-colored, non-crystallizable extract known as *mutter-lauge* (mother-lye), very rich, among numerous other elements, in chloride of calcium and bromine. This mother-lye is used extensively to gradually and systematically increase the strength of the baths from time to time. The physicians, by the use of mother-lye, are able at will to increase the elements in the bath capable of causing peripheral irritation, and peripheral irritation, properly applied, has much to do with the successful outcome of the baths.

The thermal brine bath, which is the one most cardiac cases take at the outset of the bath treatment, is a reddish-brown



liquid, looking much like a puddle of dirty water in a clay-bed after a heavy rain. This color is caused by the escape of the carbonic acid gas into the atmosphere as the water is thrown up from the earth into reservoirs. The loss of carbonic acid gas permits of only partial solution of the iron and chloride of calcium.

The sprudel or effervescent baths are sparkling and clear as crystal, and, while having their source in the same springs as the thermal brine, viz., Nos. 7 and 12, are brought directly to the bath-tubs by means of pipes running from the springs in the interior of the earth without prior exposure to the atmosphere, and consequently without escape of the natural carbonic acid gas.

The sprudel strom (current) is a continuous effervescing of water flowing in and out of the tub while the bath is being taken. This bath is an exceedingly powerful one, employed with the greatest circumspection in cardiac cases. So far, it has not been possible to successfully imitate the sprudel strom.

Upon the therapeutic virtues of the last three baths, the thermal brine, the sprudel, and the sprudel effervescent, much of the good work performed at Bad Nauheim depends.

Can we imitate these baths successfully at home? Yes, the first two fairly well. While a large number of mineral elements are present in the waters of the Grosser Sprudel and Freiderich Wilhelm's Quelle, the really active ingredients are thought to be *chloride of sodium*, CHLORIDE OF CALCIUM, and CARBONIC ACID GAS. I myself, however, cannot but believe that the iodine and bromine (and possibly the arsenic and silica) have much to do with the results—far more, indeed, than seems to be appreciated by the theorists.

Dr. Schott himself has long been of the opinion that to an approximate extent the Bad Nauheim baths may be artificially imitated. In severe cases, where these made baths are used, the treatment should commence with a 1 per cent. solution of chloride of sodium, and the strength gradually increased to 2 or 3 per cent. The special mineral element capable of producing the greatest amount of skin irritability (which is the precursor, or occurs *pari passu* with the desired cutaneous capillary dilatation) is the chloride of calcium. One per cent. of a solution of this salt should be added, the amount being gradu-

ally increased, in successive groups of baths, until 2, 3, and finally 5 per cent. is reached. The 2 per cent. amount fairly approximates the quantity in the Grosser Sprudel and the 3 per cent. that of Freiderich Wilhelm's Quelle. Imported mother-lye contains the chloride of calcium, as does also some of the halogen salts and Mediterranean sea-salt.

Roughly speaking, from five to ten pounds of chloride of sodium and from half a pound to one pound of chloride of calcium, added to forty or fifty gallons of water (Greene) are proportions that may be used in the preparation of the first series of baths. In this manner could be imitated, to a certain extent, the so-called thermal brine.

The temperature of the first bath, unless there be present contra-indicating reasons, should be 92° F. for cases not specially bad. The temperature should be lowered a half or a whole degree, say after a group of three baths given on successive days. A pause in the bathing should take place after two or three baths. The temperature of the water should not be permitted to go below 83° F., and must only reach this low point after a careful consideration and a gradual lowering a half or whole degree at a time in successive baths.

The duration of the first bath should be from five to eight minutes, and the time of immersion increased by a minute each following bath until finally the extreme limit of twenty minutes can be reached.

The patient must be personally watched by the physician in the first few baths, and, possibly also, at the beginning of the baths of longer duration, in order to obviate or control syncope. A chill in the water must lead to the immediate taking of the patient from the bath. This precaution does not refer to the little precursory shiver the patient feels when he first enters the water. The shivery sensation is soon followed by one of agreeable warmth. Baths that have induced chill should lead to the giving of the next series at a higher temperature, lowering it gradually in successive baths until the patient becomes inured and can more than stand the temperature at which the chill occurred.

While in the bath the patient must remain absolutely motionless. After being thoroughly dried, when the bath is over, the patient must rest or sleep for an hour or two. The baths, of course, must not be taken soon after eating.

After about twenty or twenty-five baths have been given of the so-called thermal brine variety, it is often advisable to modify the baths so as to give them an effervescing character, in imitation of the sprudel baths of Nauheim. This is done by using the chlorides of sodium and calcium as in the first course of baths, and introducing carbonic acid gas. Carbonic acid gas effervescence can be produced by the action of hydrochloric acid on the bicarbonate of soda.

By the employment of different methods the gas can be made to evolve slowly or rapidly. When slow production is deemed best, the various salts, including the proper proportions of bicarbonate of soda (after being dissolved in the water of the bath), a bottle containing the hydrochloric acid is laid at the bottom of the bath-tub, and, the stopper being removed, the bottle is moved about from time to time. By this slow method two or three hours elapse before the bath is ready for use.

Rapid effervescence is secured by partly removing and still partly retaining the stopper of the acid bottle. The bottle is inverted and lowered until its mouth is just below the level of the water, when the stopper is drawn and the bottle moved about, so as to diffuse a layer of acid as uniformly as can be over the surface of the water. About five minutes is all the time required to prepare this bath.

These so-called effervescing baths, imitations of the sprudel, can be made in three degrees of effervescence:

*Mild.*— $\frac{1}{2}$  pound  $\text{NaHCO}_3$  to  $\frac{3}{4}$  pound  $\text{HCl}$ . (25 per cent.)

*Medium.*—1 pound  $\text{NaHCO}_3$  to  $1\frac{1}{2}$  pound  $\text{HCl}$ .

*Strong.*—2 pounds  $\text{NaHCO}_3$  to 3 pounds  $\text{HCl}$ .

This is Dr. Bezly Thorne's method of preparing the artificial effervescing sprudel. Except where a porcelain tub is used, "a slight excess of alkali should be used in order to prevent corrosion."

Dr. Greene makes the effervescing bath by adding six ounces of bicarbonate of soda and seven ounces of hydrochloric acid to the brine water.

The temperature of these baths must be most carefully regulated. It would be wise to duplicate the Nauheim temperatures of corresponding baths. It is thought that the lower the temperature at which the bath can be taken the better, but



the rule is not without exceptions. In rheumatics, for instance, a cold bath might induce an acute attack.

When beginning a new series of baths, that is, the second stage of bath treatment, the effervescing sprudel, you permit the first bath to occupy five to eight minutes, as in the thermal brine, and gradually increase the duration day by day, of course giving a day of rest between every three baths, until twenty baths have been given. At this stage it may be wise to interrupt the course of treatment for two, three or more weeks, and then recommence if the effect produced has not been sufficient to render the patient comfortable. Certainly the baths should not be continued too long. A course at Bad Nauheim is from five to seven weeks, and they do not, to my knowledge, give a double course without previous interruption. Good judgment must dictate the next step.

A lower temperature may be employed in the effervescing than in the thermal brine, because of the warming effect of the contained carbonic acid gas. However, the lower temperature must be reached by slow degrees. It is best to begin at 92° F., if there are no contra-indications. Warm water may be employed to elevate and ice to lower the temperature.

The effect of the baths is to reduce the size of a dilated heart, diminish the number of pulse-beats, fill the arteries, partially empty the veins, open up the cutaneous capillaries, and inaugurate a rehabilitation of a damaged heart-muscle by reason of nutritional changes. The capillary congestion is most marked in some instances, the patient coming out of a sprudel bath red and glowing. I can liken the effect to nothing so likely to convey a correct impression as to say: It is the bleeding of a patient into his own capillaries. The baths are unquestionably "tonic." These effects are sometimes produced by the first baths. Of course they are not lasting. A repetition of the bath brings about the same series of results, and ultimately, by the effects being gained over and over and over again, sometimes complete compensation in a dilated heart is achieved.

Fatty degeneration, myocarditis, the absorbable remains of recent pericardial and endocardial inflammations, angina pectoris, Graves' disease, functional disorders, and, above all, dilatation or dilatation secondary to valvular lesions, are helped by

the treatment. In some instances permanent, and in others partial, restoration of muscular heart-power takes place.

Advanced arterio sclerotics, advanced Bright's cases, as well as aneurism patients, are not recommended to take the baths.

You may be sure that such mighty engines for good as these baths, in the hands of a tyro, may do irreparable harm. The time, the temperature, the amount of minerals in the water, the quantity of carbonic acid gas, the periods of repose from bathing, are all matters calling for fine, well-balanced judgment. I beg of you not to recklessly plunge all your cardiacs into thermal and sprudel baths. You must make a careful, exhaustive diagnosis as to the heart-muscle's capabilities. You must weigh every possible factor in the case. In the hands of experts these baths produce good results. In the hands of mere empiricists, men who do not strictly individualize, the baths distinctly do harm. I am impelled to utter this note of warning. I am of belief that, without a thorough knowledge of the patient to be treated, no man has a right to take the big risks of experimenting. There is not one household in a hundred where I would personally give these baths, and even then I would give the case my personal supervision in the first few baths. I would trust no one to do that work for me. The Bad Nauheim method, I think, ought, save in very exceptional cases, to be pursued in a sanatorium under the care of a specialist in cardiac diseases, and one, too, who by nature is cautious, well-balanced, judicial, and not over-enthusiastic.

#### THE MOVEMENTS.

The second great measure Schott employs in suitable cardiac cases is the so-called "resistance" movements. With the exception of not producing nearly so great capillary dilatation and a far more gradual slowing of the pulse-rate, the movements are said to produce the same effects as the baths. In some cardiacs baths alone are used; in some, movements alone; but in most cases both baths and resisted movements are employed. About a week after the baths have begun to have an effect, the movements are begun; sometimes the reverse course is pursued. Please do not think for one moment that these exercises are simple "gymnastics." The purpose of the exercises is to secure such action of muscle as will cause very little

exertion and no fatigue, in order to develop and strengthen the heart-muscle. It must be remembered, too, that these movements are to be "regulated" by the patient and "resisted" by the operator.

Following is a list of the movements, and a description of the manner of executing them by the patient and of resisting them by the operator. I am almost wholly indebted to the work of Dr. W. Bezly Thorne, of London, England, for this description.

Let us consider primarily the directions to the operator.

*First.*—Each movement is to be performed slowly and evenly; that is, at a uniform rate.

*Second.*—No movement is to be repeated twice in succession in the same limb or group of muscles.

*Third.*—Each single or combined movement is to be followed by an interval of rest.

*Fourth.*—The movements are not to be allowed to accelerate the patient's breathing, and the operator must watch the face for the slightest indication of

A. Dilatation of the *alæ nasi*.

B. Drawing of the corners of the mouth.

C. Duskiness or pallor of the cheeks and lips.

D. Yawning.

E. Sweating.

F. Palpitation; and I may add, very emphatically,

G. Increase in the pulse-rate.

*Fifth.*—The appearance of either of the above signs of distress should be the signal for immediately interrupting the movement in process of execution, and for either supporting the limb which is being moved or allowing it to subside into a state of rest.

*Sixth.*—The patient must be directed to breathe regularly and uninterruptedly, and should he find any difficulty in doing so, or for any reason show a tendency to hold his breath, he must be instructed to count, and continue counting, in a whisper, during the progress of each movement.

*Seventh.*—No limb or portion of the body is to be so constricted as to compress the vessels and check the flow of blood.

Here are the movements:

No. 1.—The arms are to be extended in front of the body on



a level with the shoulder-joints, the palms of the hands meeting in front of the chest. The operator places his hands on the outer surface of the patient's wrists in such a manner that the ulnar side of the patient's wrists rests in the fork between his own thumb and forefinger. He places one foot in front of the other so that he may lean forward without overbalancing himself, while the patient's arms are carried outward until they are in line with each other and with the transverse diameter of the chest. The operator then places his hands, with a similar disposition of the thumb and forefinger, on the palmar surfaces of the patient's wrists, and offers resistance while the arms and hands are being brought back to the position from which they started.

No. 2.—The arm and hand of one side at a time are extended in the depending position, with the palm of the hand directed forward, and the operator, standing at the patient's side, places his open hand on the palmar surface of the patient's wrist, the thumb only being on the dorsal surface. The patient then flexes the forearm, without movement of the upper arm, until the fingers come in contact with the shoulder. The operator then places the palmar surface of his own hand on the dorsal surface of the wrist, and maintains it there while the flexed arm is being extended to the position from which the movement commenced.

No. 3.—The arms are extended vertically in the depending position, with the palms of the hands turned forward. After they have been raised outward until the thumbs meet over the head, they are brought back to the original position. The operator faces the patient, and resists the upward movement on the radial side of the wrist, and the downward movement on the ulnar side.

No. 4.—The hands, with fingers flexed from the end of the first phalanx in such a manner that the second phalanges of the respective fingers of the two hands are in apposition with their fellows of the opposite side, are pressed together in front of the lower part of the abdomen. The thumbs are extended, and lie within the three sides of a rectangle formed by the flexed forefingers, and touch each other at their tips. The arms are then raised until the hands are on a level with the vertex of the head. Resistance is offered by placing the hands on the radial sur-

face of the wrists. The movement is then reversed. Before the return movement is performed the operator changes the position of his hands so as to receive the wrists in the fork between his thumb and forefinger, the palmar surface of his fingers being applied to the palmar surface of the patient's wrists.

No. 5.—The extended arms are placed in the depending position, with the palms of the hands resting against the thighs. They are then raised in parallel planes until vertically extended. The movement is then reversed. The operator faces the patient; and, in order that he may maintain a uniform and effectual resistance, the relation of his hands to his patient's wrists must pass through the following changes: In the first position the fork between his thumb and forefinger must be applied to the radial part of the wrist. As the arms rise to an angle of  $45^{\circ}$  to the body, his fingers are around the wrist until they are lightly folded around the radial surface of the wrists. Before the reverse movement commences he receives the ulnar aspect of the wrist in the fork between his thumb and forefinger. While the arms are descending his thumbs move outward, and at the same time the fingers glide around the dorsal surface of the wrist in a direction opposite to that which his is taking, in such a manner and at such a rate that when the patient's arms are on a level with the shoulders the ulnar aspect of the wrist rests on a reversed fork formed by the radial aspect of the operator's forefingers and the thumb pushed out to a right angle with the somewhat flexed fingers. As the hands descend towards the thigh the tips of the operator's fingers gradually glide around to the ulnar aspect of the wrist, so as to resist the downward and backward movement of the arms. This is the operator's *pons asinorum*, but it should be mastered.

No. 6.—The trunk is flexed forward, without the knees being bent, and then brought back to the erect position. The operator stands at the patient's side with one hand over the upper third of the sternum and the other supporting the mid-lumbar region. The reverse movement is resisted by placing one hand over the junction of the cervical and dorsal portions of the spine.

No. 7.—The trunk is rotated, without movement of the feet, as far as it can be carried to one side, say to the right, then to the left, and lastly brought back to face forward, as at starting.

The movements are resisted by one hand being placed in front of and a little above the advancing axilla, while the other is placed over the receding shoulder. The operator must, to a limited extent, move around the patient when the second stage of rotation is being performed, and will be able to do so most evenly and securely by carrying one foot around behind the other, somewhat as is done in performing the skating "outside edge backward," before shifting the position of the other.

No. 8.—The trunk is flexed laterally, first to one side, secondly completely over to the other, and thirdly, brought back to the erect position. The operator stands in front of the patient. When the movement is to the right, his left hand is pressed against the right side of the chest in the axilla, while the right firmly supports the opposite hip, and *vice versa*.

No. 9.—This movement is identical with No. 1, with the exception that while it is being executed the fists are kept firmly clenched.

No. 10.—The arms are flexed in succession as in No. 2, with this difference, that the palmar surface is turned outward, and the fist is firmly clenched.

No. 11.—The arm is extended in the depending position, the palm of the hand lying against the thigh, and then makes a complete revolution from the shoulder-joint, forward and upward, until it is vertically raised alongside of the ear. Before it descends backward, the palm of the hand should be turned outward. The operator stands at the patient's side, with his fingers folded around the radial side of the wrist. His other hand must be ready to receive the wrist when it reaches the vertical position, and to maintain the resistance until the arm has descended to the position for which it started. This movement is performed by one arm at a time.

No. 12.—The arms are extended vertically in the depending position, the palms of the hands resting against the thighs. They are then moved upward and backward in parallel planes as far as it is possible to do so without bending the trunk forward. The upward movement is resisted by the fork of the hand on the ulnar aspect of the wrist, the downward by folding the fingers around the radial surface.

No. 13.—The patient stands with one hand resting on a chair or table, while the thigh of the opposite side is flexed on the



trunk to the extreme limit, and then extended until the feet are side by side. The leg should hang downward from the knee-joint. The upward movement is resisted by a hand placed immediately above the knee. The return may be resisted by a hand placed below the lower part of the thigh or under the sole of the foot.

No. 14.—The patient, supporting himself with one hand, as in the last movement, bends the whole extended lower extremities in succession, first forward to the extreme limit of movement, then backward to the same degree, and finally brings the one foot alongside of the other. The forward movements are resisted in front of and above the ankle, and the backward movement behind.

No. 15.—The patient, supported in front by a chair or table, stands on either foot in succession, while the leg of the other side is flexed on the thigh. The upward movement is resisted by pressure on the heel, the return movement above the instep.

No. 16.—The patient, resting one hand on a chair, and standing on the foot of the same side, raises the extended lower extremities in succession outward, from the hip-joint, and then reverses the movement. The operator resists by means of one hand placed above the ankle.

No. 17.—The arms, extended horizontally outward, are rotated from the shoulder-joints to the extreme limits forward and backward. The movements may be resisted by the operator grasping the ulnar edge of the metacarpal portion of the hand, or by closing his thumb and forefinger in a ring around the wrist.

No. 18.—The hands, in succession, are first extended, then flexed on the forearm to the extreme limits, and lastly brought into line with the arm. The operator's one hand supports the wrist, while the other resists the movements at the metacarpal phalangeal junction, first on the dorsal, secondly on the palmar, and thirdly again on the dorsal surface.

No. 19.—The feet, in succession, are flexed and extended to the extreme limits, and then brought back to their natural position. The movements are resisted in the dorsal and plantar surfaces, at about the level of the metatarso-phalangeal joints.

These are the movements, then. But the physician must direct the time required, the amount of resistance offered, and, in fact, should be at the first seance himself, and oftener, if re-

quired. Each case must be individualized. Patients in bed can take but few movements, and massage may be ordered. Massage, however, is a poor substitute for the Schott movements. Massage does some little good, and may assist in getting the patient into such a condition that the movements proper can be commenced. An exhaustive examination of the patient must be made, and an accurate diagnosis formulated. The movements may produce rapid, even fatal syncope, in patients who have a serious impediment to the quick filling of the arteries and capillaries expanded by the exercises. Such an accident is most likely to occur in cases of advanced emphysema, with great obstruction in the pulmonary circuit from an obliteration of blood-vessels or an intercurrent attack of asthma. In aortic stenosis, if grave, great care must be exercised. There is here, as you are only too well aware, an obstruction to the rapid outflow of blood into the systemic circulation. In such instances the movements should be executed with snail-like slowness, and the resistance offered the patient be scarcely appreciated, barely the weight of the hand lightly touching the proper part. The interval of rest between the movements must also be considerably more than in ordinary cases of dilated heart. The cardiac apparatus, heart and vessels, must be allowed time to accommodate itself to the new order of things induced by the movements. Recumbency should, in some instances, be insisted upon, particularly if cerebral anæmia be apprehended. In great distention of the right heart, downward movements of the upper extremities from above the head should at first be proscribed. Gravity would assist in redistending the ventricle and so defeat the object of the movements.

Most emphatically I assert that these movements, improperly applied, can do incalculable harm. On no account should they ever be given a patient save at a physician's recommendation, and then only after a careful and exhaustive consideration of all the factors in the case. A nurse, acquainted with the movements, who dares to give them unprescribed, deserves to be cut and quartered. We have had too much damage done by self-opinionated nurses. To give these movements to every case of "heart disease" indiscriminately is more than likely to result in doing more harm than good, and, besides, will lead to the condemnation of a method that, properly applied, is one of the great discoveries of the age.

If possible, train your assistants yourself. Not every one makes a good operator. A really first-class operator is a scarce article even at Bad Nauheim, as I personally know. A fellow who goes through the movements without "brains" will not do. An operator must have good judgment, keen powers of observation and fine manipulative tact, and he must not have an acromegalic cranium.

When one has become thoroughly versed in giving and taking the movements, in other words, not only acting as a patient, but also as an operator, it is possible to give oneself the movements by means of "self-resistance" of opposing muscles, thus doing away with an operator. It must be remembered, however, that an operator is always to be preferred when one can be secured. The self-resistance is brought about by hardening the muscles which are to be exercised. In a little while one can at will produce sufficient muscle firmness to bring about fairly good results.

In closing, let me briefly say that the chief indication for the baths and movements is incompetency of the cardiac muscle, and the chief injunction is extreme caution.

The method ought not to be considered a miracle-worker, but a valuable addition to the means of treating certain cardiac diseases, far surpassing, in many cases, the ordinary treatment by drugs alone.

---

#### FORMALDEHYDE—ITS PRACTICAL VALUE AS A DISINFECTANT.

BY ROLAND T. WHITE, M.D., ALLEGHENY.

(Read before the Homœopathic Medical Society, State of Penna., Pittsburgh, Sept., 1898.)

SINCE the discovery of the valuable germicidal properties of formic acid and its derivatives, especially formaldehyde ( $\text{CH}_2\text{O}$ ), many elaborate and ingenious methods have been devised for its use as a disinfectant.

The *sine qua non* of an ideal disinfectant would seem to be, first, to obtain the highest degree of efficiency; and, second, that in its application the method may be thoroughly practical and economical.

These requirements are largely fulfilled by formaldehyde.



The earlier experiments with formaldehyde were mostly along the line of generating the active formic aldehyde gas in volume sufficient to give the necessary percentage to an atmosphere to destroy micro-organisms by the oxidation of methylic alcohol, usually termed the retarded-combustion method.

Although a seemingly practical and economical procedure, its utility was soon brought into question by the uncertainty of control as to the amount of alcohol consumed and the volume of formic aldehyde set free; and as, up to the present time, no apparatus has been perfected which will overcome these difficulties, the retarded-combustion process has largely been discarded. Pariform pastilles or polymerized formaldehyde do not seem to readily part with their original percentage of formic aldehyde, and necessarily increase the expense of disinfection with this agent, holding no advantage over the aqueous preparations.

Dr. Novy, in a recent contribution to the *Medical News*, gives the comparative germicidal powers of sulphur and formaldehyde as disinfectants in a series of elaborate and painstaking experiments, demonstrating conclusively the superiority and practical utility of formaldehyde.

A closed vessel, heated by a Bunsen burner, with a long extension spout connected with the top and of a calibre small enough to pass through an ordinary keyhole, comprised his generator. This apparatus has the important advantage of being operated outside the room to be disinfected. An apparatus similar to Dr. Novy's has been adopted by the bacteriological department of Allegheny, and the satisfaction it has given both in practical use and numerous crucial experiments leads me to direct your attention to this effective method of disinfection. The apparatus consists of a vessel made of heavy copper-brazed seams, thirty-five ounces capacity, a cone-shaped spout from the top, an alcohol stove being used to volatilize the formalin. Five fluid ounces of commercial formalin (40 per cent.) is required for each 1000 cubic feet of space. Dr. Burns, city bacteriologist, has made numerous experiments with this method, demonstrating with reasonable certainty the rapid and effective sterilizing of a variety of contagions, among them diphtheria, tubercular bacillus, streptococcus pyogenes, etc. A brief description of an epidemic of diphtheria during the past winter

may prove instructive, illustrating not only the value of thorough disinfection but also the importance of a careful search after origin and cause in epidemic diseases.

In a circumscribed section of the city of Allegheny diphtheria suddenly became alarmingly prevalent—very few cases being reported at the time from other portions. Reports of new cases continued to come in rapidly in the face of quarantine and house disinfection where the cases existed.

Suspicion was finally directed to the local school building, the school was closed, and the building thoroughly disinfected by the formaldehyde process, which immediately stopped the spread of the contagion, only one case thereafter developing.

Personal observation and a variety of experiments during the past five years lead me to a positive belief in the superiority of formaldehyde as a germicide over sulphur, with its pungent sulphurous acid fumes.

A small quantity of borax should always be added to the formalin to prevent polymerizing during evaporation; and the usual careful technique in sealing the room to be disinfected, spraying walls, moistening materials generally to be acted upon, suspending blankets, linen and clothing upon lines, etc., must always be carried out carefully. All fabrics to be acted upon must be moist, as a valuable agent may prove inadequate if carelessly or indifferently applied.

---

### PUNCTURED WOUND OF THE COMMON CAROTID ARTERY.

BY H. L. NORTHROP, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Pittsburgh.)

IN the early days of surgery operators entertained a wholesome fear of blood-vessels. No structure, perhaps, was kept so constantly in mind, and before the mind's eye, as the artery or the vein; no part received such deference from the surgeon as the vessel upon whose integrity, it was thought, the success of the operation depended.

The earlier works on surgery contained chapter after chapter upon the relative position and course of the veins and

arteries and their branches, and the surgeon then was *necessarily* a good anatomist. He depended upon his knowledge of anatomy to enable him to locate and avoid blood-vessels, while a hæmorrhage from an operation wound was considered a disaster.

Probably this fear of encountering hæmorrhage was due to the poor and primitive means at hand of finding and tying vessels. The surgeon was obliged to pick up each vessel in turn with that antiquated, infection-causing instrument, the tenaculum, and ligate it before proceeding further. How easily, quickly and safely to the surgeon of to-day is hemostasis secured. The modern self-retaining hemostat (artery forceps or clip) has revolutionized the all-important part of an operation—blood control. Now the surgeon calls less frequently upon his storehouse of anatomical knowledge than formerly. He cuts openly, freely, boldly, anywhere and everywhere. If he encounters a blood-vessel (and he does not stop to think specially whether he is going to encounter one or not), he secures it at once with an artery clip, and, the hæmorrhage controlled, proceeds with his operation.

Hence we understand why the surgeon of to-day has little fear of hæmorrhage. In accident and operation wounds, where enough blood has been lost to cause serious shock and collapse, the surgeon has at his command, in infusion, the means of replacing the vital amount lost—not with blood, but with something which answers every purpose for the time being, namely, salt-water; and thousands are alive to-day who would be in their graves had it not been for the infusion of saline solution into the circulatory system at the time they suffered a severe loss of blood. It's a poor rule that won't work both ways. The old-fashioned doctor opened a vein to let out blood; now we open one to put in blood, or its substitute.

Arteries and veins have no fear for us; loss of blood gives us no alarm. At least such had always been my feeling in this matter until I was brought face to face with a hidden, punctured wound of the common carotid artery; for whose majesty, when so punctured, I will evermore entertain a most profound respect.

Harry Gilson, a boiler-maker, was struck in the neck by a



flying piece of steel, which caused free hæmorrhage. The steel was unsuccessfully probed for at the Samaritan Hospital, Philadelphia. He was sent home, and advised to report at the dispensary on the following day. During the night his dressings were soaked with blood, his respirations became embarrassed, and the police patrol brought him to the Hahnemann Hospital at 2.15 A.M. The bleeding having ceased, no immediate treatment was necessary, and I saw him early that morning. He was a large, muscular fellow, with a thick neck, naturally. Upon removing the dressings I saw a wound one-half inch long over the anterior surface of the right sterno-mastoid muscle, one and one-half inches above the clavicle. Both sides of the neck, the right the worse, were considerably swollen, and respirations were slightly interfered with. His voice was thick, tight and hoarse, and I suspected beginning œdema of the larynx. I attempted the use of the laryngoscope, but the patient could not open his mouth enough to show even the base of his tongue. I told him it would be folly to try to find the steel, which had cut a deep vessel; that the best plan was to let him alone and await developments.

He was then placed in bed, upright, with ice-bags surrounding his neck, and one-eighth of a grain of pilocarpine was injected into the neck tissues on the left side. Liquid diet was ordered, and the nurses were instructed to watch him constantly. In two hours I was summoned by telephone, with the report that the patient's neck had swollen enormously and breathing was seriously obstructed. Upon reaching the hospital I found Gilson restlessly walking around, fighting for breath, and hardly able to articulate. Preparations were immediately made for tracheotomy.

With the patient sitting upright on an operating table, I injected cocaine beneath the skin in the median line. In this, and throughout the operation, what there was of it, I never made more strenuous efforts to work in the median line, realizing that the hematoma, present to a greater degree upon the right side, had probably caused more or less displacement of the trachea and contiguous structures.

An incision through the skin revealed all the neck tissues thoroughly infiltrated with blood, and so discolored that they were recognized with difficulty. I worked my way carefully

down through the thickened neck, and when I reached the trachea the wound was three full inches deep. So far knife or scissors had been employed very little, and I now used only my finger to determine whether the trachea was or was not in the median line. While palpating gently on the right side of the trachea, my finger broke through a thin connective tissue barrier. At the same time a cloud-burst of arterial blood drenched everything in the patient's immediate neighborhood. The swelling of the neck disappeared simultaneously with the hæmorrhage. I thrust two fingers into the cavity and compressed the neck tissues, and then poked in a tampon, packing the rest of the wound with iodoform gauze. Now I appreciated the fact that the piece of steel had wounded the common carotid artery, and that this vessel would have to be ligated. That, of course, was out of the question at this time. The patient was practically pulseless, and was beginning to lose consciousness. Without delay he was placed flat on his back, with his head low, and three quarts of salt solution were injected into the median basilic vein of the left arm. This was promptly successful, the pulse becoming full and steady. For three hours we held compresses in place in the wound, and thus controlled the hæmorrhage. It then became necessary to infuse again.

I now passed my finger into the lower angle of the wound, and reached a point directly behind the right sterno-clavicular joint, the origin of the right common carotid artery, when I felt the full, distended, pulsating vessel. Guiding a clamp along my finger, I caught the artery, and gently removed the packing from the wound. There was no further bleeding, and the wound was repacked as before.

The patient received full diet, milk punches, hemaboloids, china  $\phi$ , and aromatic spirits of ammonia. He recovered promptly from the shock.

Fearing the clamp would ulcerate through the vessel wall, and that the last state of that artery would be worse than the first, I decided to attempt to ligate. That was forty-eight hours after the application of the clamp. The patient was in no condition to take a general anæsthetic, so I carefully removed the gauze pack, and found the clamp had lost its hold on the carotid, probably forced off by the blood-pressure

within. At this juncture, without any provocation, a quantity of blood escaped from the steel wound in the artery above, and immediate application of the clamp and repacking of the wound were necessary, and put a stop to any further attempts at ligating. The patient was again infused.

Four days later the clamp was carefully removed and the wound repacked. No bleeding. Patient improving, gaining strength and color.

Twelve days after admission, while eating supper, bleeding recurred. Several clamps and clips were applied by the resident surgeon to the deepest part of the wound, as accurately as possible on the carotid artery, and two quarts of salt solution, with four ounces of brandy, were injected into a vein in the right arm. Patient's pulse reached 160.

The behavior of this wound plainly told us to keep hands off. A look even seemed sufficient to start the leak. Should hæmorrhage suddenly occur, the nurses were instructed to pass a finger deeply into the lower angle of the wound, and make firm pressure until aid could be summoned. The patient was kept flat on the back, and cautioned not to lift his head or make any exertion. And he obeyed to the letter.

One day his temperature reached 105°. His color had now become thoroughly cachectic, his face swollen, his hands and feet numb, with a right-sided hemiplegia, and he was delirious. He presented a picture of profound anæmia. In the meantime, his wound was being most gently dressed every other day with castor oil and balsam of Peru (5 per cent.), and appeared to be granulating nicely, though the granulations were very pale in color. We did not dare to probe the deep part of the wound.

On the fifteenth day after admission a gush of blood compelled me to try to put a stop to this series of troublesome, life-sapping hæmorrhages. I therefore made preparations to ligate. Injecting cocaine along the anterior border of the sterno-mastoid muscle, and incising the superficial structures in this direction, I cut through the sterno-mastoid muscle transversely to enlarge my working-space, lifted up the right lobe of the thyroid gland, and, because of the depth of the wound, with difficulty exposed the common carotid artery and internal jugular vein. All this time an assistant's finger compressed the carotid over the wound in its wall, thus partially



controlling hæmorrhage. I now attempted to pass a ligature around the carotid artery about one inch above its origin, but failed because I could not disturb the vessel enough to liberate it from its connective-tissue bed. I ran too great a danger of perforating the jugular vein. The bleeding was absolutely beyond our control, and further efforts at ligature would have exsanguinated our patient, already semi-unconscious from the phenomenal bleeding he had been subjected to. After consultation with Dr. W. B. Van Lennep the clamp was again resorted to, and was applied accurately to the carotid, but did not—could not—include the entire vessel, for when this was done the most excruciating pain ensued, through clamping of the pneumogastric nerve. Our efforts at ligature were thus completely frustrated, and we had to be satisfied with the hope of closing the wound in artery and neck by granulation tissue. The patient now had six clamps and clips in his neck wound, and these were gradually loosened by the blood-pressure, so that in five days they had to be removed.

On the 25th of July hæmorrhage occurred for the sixth time. The wound was repacked tightly and the patient infused.

No further bleeding for the present. The wound then began to look more active, to granulate nicely, and the deep part apparently closed. Patient's general condition was much improved. He was allowed to sit up in bed on August 5th, and two days later enjoyed a rocking-chair for about one hour. August 9th his evening temperature was 99°, pulse 116. He slept quietly until midnight, when he awoke with a start, bled profusely, and died before aid reached him.

The post-mortem examination showed a wound one-half inch long in the anterior wall of the right common carotid artery, with a piece of steel one-half inch long, three-eighths wide at one end, and sharply pointed at the other, lying transversely in the artery one inch above its perforation.

I trust that the strenuous efforts I made to control the hæmorrhage from this man's neck are apparent to those who review this case with me, just as the predicament I was in was appreciated by all who witnessed the operations or assisted in the care of this unfortunate patient. Unable to administer a general anæsthetic, because of the strong likelihood of a fatal hæmorrhage being produced by the patient's struggles and the in-

creased arterial tension and circulatory excitement; unable to release the artery sufficiently from its connective tissue sheath to ligate it because of the impossibility to successfully compress it, and thus completely control the hæmorrhage, even for a short interval, I was more than once compelled to keep hands off and stand at a distance from this menacing carotid wound.

The chief warning to be noted in this case is that any physician is liable to encounter the same kind of a wound; mechanics in many country shops are exposed to the same danger and the same accident. Fortunately wounds of the common carotid are not of frequent occurrence in times of peace, though bullet and sabre wounds of this vessel are met with frequently in war.

A perusal of the surgical volume of the *Medical and Surgical History of the War of the Rebellion* gives a total of seventy-five ligations of the common carotid with a mortality of 78 per cent. One table of fifteen cases of ligation of this vessel for gunshot injuries records the death of every case. But this high rate of mortality may have been due, in great part, to the absence of antisepsis. The surgical history of the Hispano-American War is therefore awaited with great interest.

Swasey (New Britain, Conn.) reported a successful ligation of the common carotid artery and internal jugular vein after penetration, in *The Medical Record*, February, 1888. Swasey's patient was struck in the neck by a piece of steel flying from a hammer. It was deemed inexpedient to give an anæsthetic. Laying open the neck tissues freely, he found the sterno-mastoid muscle had been divided by the chip of steel through nearly three-fourths of its substance, which fact facilitated the search. By the application of four pairs of artery forceps the hæmorrhage was controlled, then the sheath was dissected from the vessel, and braided silk ligatures were applied. The jugular vein was reached by slitting up the sterno-mastoid, and although the patient was supposed to be dead during this procedure, he finally rallied and recovered.

---

TWO CASES OF HALF-PENNIES IMPACTED IN THE ŒSOPHAGUS FOR FIVE AND SIX MONTHS RESPECTIVELY, REVEALED BY X-RAYS AND REMOVED. —Robson, A. W. M. (*Lancet*, July 16, 1898). In both cases, by means of Roentgen photographs, the coin was found impacted in the œsophagus at a point opposite the pericardium. Both were removed by the Smith coin-catcher.

## EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

## THERE IS NO GREAT AND NO SMALL.

TRULY this is the age of the apotheosis of the apparently insignificant. The germ-theory of disease has raised to the throne of universal empire the whilom plaything of the microscopist and pathologist, and has assigned to it, as ministers of state and envoys plenipotentiary, the persistent fly and the vicious mosquito.

While the tantalizing hum of the latter suctorial formerly aroused only wrath and ineffectual blows and subsequent scratching, now, in the atmosphere of scientific investigation, it threateningly sings of malarial infection. The bite which then raised only our ire and a weal, now implants paludal poison.

Not long since the phlegmatic fly harmlessly titillated our bald heads, or buzzed monotonously before our sleepy ears, or crawled cooly, but clingingly, over the butter or out of the sweetmeats. Now he is shod with disease and his feet are loaded with death. Evidence has accumulated that in him we have an active agent in spreading contagion and causing epidemics. Typhoid and dysentery literally follow in his footsteps. Now has fly-paper become a needful hygienic appliance, and mosquito-netting an imperatively-demanded prophylactic.

No longer can our sympathies be expected to go out to the confiding fly, struggling to free himself from the all too adhesive attraction of the glistening sheet of fly-killer, nor to the dying mosquito, whose last hum is being drowned in a pool of mixed blood, shed by our irate hand. Only with grim satisfaction can we now view the merited end of existences proved to be so detrimental to our own.

The knowledge that these apparently harmless though obtrusively troublesome little pests are emissaries and carriers of the all-potent germ will cause us to revise and reduce to Draconian simplicity our code of hygienic laws for camp, kitchen, and household.



## TELLING FACTS.

NOTHING succeeds like success. To him that hath, to him shall be given.

All efforts to gain recognition, public or private, for homœopathy, based upon general principles of justice and equity, while, no doubt, doing some good, do not begin to compare in their results with the ability to point to concrete facts illustrating the successes which homœopathy has already gained and is continually gaining.

It would be impossible here to enumerate the many directions in which homœopathy is progressing towards that position which justice and its own merits demand. We wish only to point to two or three as illustrative.

We said a couple of months ago that we should in times of war prepare for peace, and that has been done with encouraging success. A number of appointments of our physicians to positions in the army and navy were made by the executives of several different States, and finally in the appointment of Dr. Oscar LeSeure, of Detroit, as brigade-surgeon, with the rank of major, we have the same recognition by the national government. A decided step in advance, and one which, in the light of the surgeon-general's definition of "regular," cannot be retraced. It will now rest in a great measure with us whether it shall be followed by others of the same kind.

Again, in the acceptance of our proffer of hospitals for the reception of sick soldiers returning from the war, homœopathy has received recognition from the national government. It is true that at first here in Philadelphia it seemed as if it were accorded grudgingly, and there was a disposition manifested by subordinates to assign as few as possible to our hospital. An appeal to the representative of the surgeon-general corrected that, and was effectual in giving us all we could accommodate.

In the Hahnemann Hospital sixty-eight soldiers have been and are being treated. This number may seem small when compared with the hundreds packed away in some of the other institutions, but we chose rather to do only that which we could do well, than to sacrifice to the eclat of numbers the

comfort and well-being of our patients. We did not consider the emergency so pressing that we were called upon to violate all rules of hospital hygiene by packing in cellar and garret patients whom our wards could not comfortably receive. This has naturally caused comparisons to be instituted, not to the detriment of our hospital. Several instances have occurred where relatives or friends of patients have procured their transfer to our hospital from others, after having there suffered discomforts—to use a mild expression—scarcely less than those endured in the field hospitals. Such facts, which are sure to become widely known on the return of the patients to their homes, will contribute much to gain for the equipment of our hospital and for the efficacy of our treatment a commensurate recognition from the public, and to them in the last instance every appeal must be made.

Another telling fact, of special importance when seeking to gain control of an insane hospital in Pennsylvania, is the successful conduct of similar institutions by homœopaths in other States. According to figures quoted in the *Medical Century*, while the statistics of the insane hospitals in Massachusetts and New York show a superiority in the results of treatment over allopathic institutions, those of the Fergus Falls Hospital in Minnesota exhibit a better recovery record and a lower death record even than these. The First Insane Hospital of Missouri, in Fulton, lately put under homœopathic control in spite of most venomous opposition, as we recorded at the time, shows an eight per cent. death rate against a 9.9 rate during the last year of old school control, although the number of inmates had largely increased. An appeal to such demonstrations of our ability to assume the successful control of public institutions must be followed by a willingness to entrust more to our care, especially if we have the public on our side. Everywhere we find that professional jealousy and bigotry are in the end powerless against public opinion.

Another fact which can be noted as illustrating the onward progress of homœopathy is the continued prosperity of our colleges throughout the land. In spite of the long-lasting financial stringency there has been no marked diminution in the number of those desiring to study homœopathy. We do not know the figures as to the entering classes in other

institutions, but in the Hahnemann College of Philadelphia the number is slightly in excess of last year. This is peculiarly gratifying at this time, for it shows that at least that part of the resolutions passed at the late session of the State Society relating to the continued confidence of the profession in the College and its instructors is being verified. Of course it was hardly to be feared that anything, when impartially investigated, would be able to shake the confidence which this institution has enjoyed for fifty years, or could in the least detract from the reputation which it has made for itself, and which it is to its own interest to preserve untarnished. Its present prosperity in a city abounding in medical schools, and the prosperity of the other now so numerous homœopathic colleges elsewhere, are striking proofs of the recognition which is accorded to the medical training given in them.

Let us build upon our deeds, not upon words.

Our past successes furnish the best foundation for hopes of still greater ones in the future.

---

THE SURGICAL TREATMENT OF STERILITY.—At the Boston meeting of the American Gynæcological Society the subject: "The Surgical Treatment of Sterility: How Far is it Justifiable or Expedient?" was discussed by Dr. Matthew D. Mann, Professor of Gynæcology in the University of Buffalo. He considered the surgical treatment of sterility due to (1) malformation of the vulva and vagina; (2) atresia of the vagina dependent on disease; (3) laceration of the cervix; (4) stenosis of the os; (5) displacements of the uterus, and (6) endometritis. Suitable operation was advised in the first class of cases, provided the existence of the uterus and appendages could be made out with reasonable certainty. In atresia of the vagina efforts should be made to open the canal if the patient be young. This condition, however, is one which usually afflicts elderly women, in whom surgical interference is not indicated. Trachelorrhaphy was advised in cases in which sterility might be due to laceration of the cervix, and stenosis of the os should be treated by divulsion. Retrodisplacements of the uterus are rather conducive to conception than otherwise; therefore it is ante flexion which the surgeon is called upon to treat, and all possible means should be employed to correct the position of the organ. Endometritis is considered by the author to be by far the most common cause of sterility. For this condition he recommends forcible dilatation, curetting and packing. Before closing he called attention to the fact that in some cases the husband, and not the wife, is to blame for the sterility.—*American Journal of Surgery and Gynecology*, August, 1898.



## GLEANINGS.

---

THE MOST ANCIENT PHYSICIAN OF THE ARGENTINE REPUBLIC.—Prof. Roberto Lehmann Nitsche, of Buenos Ayres, S. A., recently demonstrated before the medical society of that city the skull of a member of a Patagonian tribe long since extinct, in fact of the age of stone, where an incomplete operation of trepanation had been commenced, but seemingly, unfortunately for that early physician, the patient died during the operation. The bone had been scraped with a stone. He asserts that this operation has been done in prehistoric times as evidenced by the skulls found in France, Spain, Portugal, Germany, Italy, Denmark, Bohemia and Russia. To-day it is practised in certain regions of Oceania and by the Kabyles of North Africa. In former times it is said to have been carried out in North America, Peru, and north and east of the Argentine Republic.—*Anales del Circulo Medico Argentino*, 1898, Nos. 7 and 8.

MICROSCOPIC EXAMINATION OF THE CONJUNCTIVAL SECRETIONS FROM A CLINICAL POINT OF VIEW.—Dr. Angieras has found catarrh of the conjunctivæ to be caused by micro-organisms in eighty-four cases out of a hundred, while, on the contrary, they are rare in eczematous conjunctivitis—thirty-four cases out of one hundred. The catarrhs of new-born children are generally due to cocci and diplococci. In adults, and especially in the acute and sub-acute aggravations of chronic cases, there is a special bacillus, which is double, at times found in broad chains, and either inclosed in the epithelia or the pus or free in the secretion. It stains easily with methyl-violet, and it measures from 4 to 6 mm., chubby and double. It presents all the morphological peculiarities of the diplococcus of the acute conjunctivitis studied by Morax. He concludes that: (1) The secretions of kerato-conjunctivitis of eczematous origin are not infectious and non-dependent on micro-organisms; (2) That the catarrhs of the conjunctiva have the very opposite characteristics.—*Revista Medica de Sevilla*, No. 6, 1898.—In a recent case of purulent conjunctivitis which came to me a microscopical examination of the secretion showed numerous diplococci to be present, which, though they closely resembled the gonococcus, the inflammation soon subsided under a boric acid lotion and argentic nitrate solution, 2 per cent., locally.

TWO CASES OF INFECTIOUS PURPURA.—Dr. J. Lapin reports on two cases of infectious purpura, with bacteriological examination. The first was that of a young girl, of four years, which was probably a case of hæmophilia, as her uncle had died of purpura, and she herself had had frequent attacks of nosebleed. There had been no rise of temperature, and her disease was cured in three weeks. Puncture of a vein in the upper arm revealed an aerobic coccus, which was to be colored according to Gram's method, and which flourished on serum and agar but not on gelatine. The second case was that

of a man, of twenty-five years, who had been in the hospital for six weeks with a valvular disease of the heart. He died in thirty hours after a febrile purpura set in. His blood contained a variety of streptococcus—a dangerous kind of infection. I am always fearful of streptococcic infection. The writer concludes that the diagnosis of infectious purpura need not be grounded on the rise of temperature, as the purpurigenic toxins need not be pyretogenic-fever-producing, and that, further, an individual predisposition, hæmophilia or heart disease is possibly necessary for its development. The negative results of injections of cultures of this coccus made in animals speak in favor of this view.—*La Médecine Moderne*, p. 225, 1898. I now have three cases of infectious purpura in one family under treatment. The first, a little girl, of nine years, began with an impetigo contagiosa, which after running untreated for three weeks developed swelling of the hands, feet and eyelids, with occasional eruptions of purpuric blotches over the whole body almost as thick as that of measles. At the same time there were numerous wheals of urticaria which itched distressingly. Apis 2x seemed to aggravate. The whole eruption disappeared in less than two days under the kali iodatum, 10 grs. in four ounces of water, one-half a teaspoonful every two hours. All works on dermatology, and particularly the French and German, mention the “purpura iodique.” I have seen iodine develop urticaria in one woman, which urticaria was very persistent and distressing, for over a year passed before it finally disappeared. Merely touching a little tr. iodine to the skin would bring on an attack. Prof. Rendu, of Paris, recently gave a lecture on purpura simplex which is very instructive.

EXTRAGENITAL LESIONS OF SYPHILIS.—Dr. Bevan says that the primary lesion of extragenital syphilis is often not diagnosed before the secondary symptoms appear. The diagnosis, he asserts, is not particularly difficult (?), as the primary lesion offers always certain characteristic peculiarities. The most frequent form is a smooth, clean, secreting and indurated ulceration, which is oftenest superficial; an excoriation would be a better term. Frequently the primary lesion is a papule and more rarely a granulating mass. Induration is seldom absent, though at times it may be but little pronounced. He records seventeen cases, none of them unusual except one of the hard palate. Finally, he is an advocate of legal management of prostitution—auch mit Recht. “To protect and save the innocent is an imperative duty.”—*Norsk Magazin for Lægevidenskaben*, No. 7, 1898. Several years ago I saw an interesting case of chancre of the tip of the tongue in a young man. The ulcer obstinately refused to heal, there was a voluminous submaxillary bubo, with a secondary eruption though scanty, and the sore itself was distinctly indurated but not very painful, with inclined or shelving edges. Hence, from these signs the diagnosis. I reported it in this journal. It has been asserted that the prognosis in syphilis of extragenital origin is less favorable. Fournier denies this.—F. H. P.

VENESECTION, EMETICS AND SPANISH FLIES.—Prof. A. Robin thinks that we are doing wrong in throwing these three standard remedies of our forefathers' therapeutics overboard and pleads for their moderate use. Venesection is to-day but little used except for a mechanical result, which is a mistaken idea, as the lowered blood-pressure soon rebounds, and acts upon

metabolism both general and respiratory. A slight blood-letting, say of 100 grammes, in a pneumonia increases diuresis, augments metabolism, the urea is excreted in greater quantity, and the destruction of the albumin of the organism decreases. A phlebotomy of 250 grammes in uræmia has the same results—a recently emphasized fact by Hurwitz.—*Deutsche Medicinische Wochenschrift*, p. 45, der Therapeutischen Beilage, 1898, and by Laache, of Christiania.

Ancient medicine taught that a little blood-letting set a renewal of the blood in motion, and recent experiments have demonstrated that a slight phlebotomy brings about a general oxidation. He recommends venesection in: (1) to reduce the blood-pressure in asystolic œdema of the lungs, etc.; (2) when nutrition is at a low ebb from insufficient metabolism; (3) in certain infections; and in (4) auto-intoxications, of which uræmia is a type. A little blood drawn then—200 to 250.0—does much good.

Emetics formerly played a gigantic rôle in therapeutics, and when rightly used act magnificently on the lungs. He finds but few contraindications even for old persons with frequent bronchitic attacks. He refers to the case of an old man of 56 years, who was arterio-sclerotic and albuminuric (slightly), and who, for two weeks, had had a severe muco-purulent bronchitis, with a temperature around 39°: no appetite nor sleep, while he was rapidly passing into a cachectic state. After an emetic of 1.5 of radix ipecac. and 0.05 tart. emetic the temperature fell from 39.4° to 37.3°, and after the second application it fell from 38.6 to 37.9°, and after a third use it became normal, and in a short time he was discharged cured. (Senega fluid extract or tincture, in one-tenth to one-half drop doses, I have found excellent in these cases.)

Blisters have his full and firm confidence. They increase "le dynamisme nerveux."—*Norsk Magazin for Lægevidenskaben*, No. 7, 1898.

**THE SAFEST HYPNOTIC FOR CHILDREN.**—Although sleeplessness in children can frequently be relieved by non-medicinal measures, it not rarely happens that the use of hypnotics cannot be avoided, and under these circumstances the question will present itself to the physicians as to what remedy is the safest and most efficient for these little patients. It is important, of course, to select a hypnotic which will be entirely devoid of narcotic influences and which will not disturb the digestion, weaken the nervous system, or leave behind a train of unpleasant after-effects. In reviewing the list of the older as well as more recent hypnotics, trional suggests itself as the one best adapted for the various forms of insomnia in childhood. Dr. J. McGee, of Cleveland, Ohio, in a recent study of the action of drugs in children (*American Therapist*) expresses himself as follows in regard to this remedy: "It does not irritate the kidneys, and is very efficient when the insomnia is nervous in its origin. The dose at one year is from two to five grains, and this is gradually increased with each year. Twenty grains have been safely given to a child of ten or twelve years. This really represents an average adult dose, but it shows the tolerance and comparative safety of the remedy. It should be given shortly before retiring, as its effect is quite rapid, although the sleep is not so prolonged as that produced by sulfonal, which it equals in power, with the advantage of prompter action and freer from unpleasant after-effects."

**CLINICAL AND BACTERIOLOGICAL STUDY OF SOME FORMS OF CONJUNCTIVITIS IN CHILDREN.**—Drs. C. Giarrè and C. Picchi, of Florence, Italy,



have studied two varieties of epidemic conjunctivitis in children. In the first and less severe variety, which was most frequently observed, there is a reddening and swelling of the palpebral conjunctiva, with a scanty catarrhal secretion which accumulates during the night in the inner canthus of the eye and sometimes is associated with irritation of the lids as a more or less intense dermatitis. Its course is long and tedious, going on for several months if energetic measures are not taken. This corresponds to the conjunctivite angulaire of the French writers. Often only one eye is first affected, but the other is soon involved.

The other variety is more serious from participation of the sclerotic conjunctiva, so that the eye assumes the appearance of the so-called "pink-eye." The secretion is more abundant, and there is often photophobia, and occasionally small conjunctival pustules or superficial ulcers near the cornea. This second variety resembles the conjunctivitis acuta epidemica of Koch-Weeks. It may begin with a short and slight febrile attack. The acute symptoms soon cease, but the case may run on for five or six weeks, if not modified by treatment. Autumn and spring are the seasons which present the greater number of cases, and in hospitals the disease may spread from bed to bed. It very often complicates measles. Microscopically, numerous diplobacilli, with a few diplococci, are found in the first form. Treated with Gram's method, the diplobacilli decolor while the other micro-organisms retain the gentian-violet. This diplobacillus resembles Friedlaender's pneumo-bacillus but has no capsule, is aerobic, immobile, develops in alkaline media, and colors well with Ehrlich's, Ziehl's and Loeffler's stains and decolors with Gram's method. In the second variety the diplococci are, curiously enough, quite scanty with a few xerosis bacilli.—*La Settimana Medica*, No. 28, 1898. *Norsk Magazin for Lægevidenskaben*, No. 7, 1898, mentions eight germs which may be detected by microscopical examination. One should prepare two specimens, one after Gram's method and the other differently. Only a portion of cases of ophthalmo-bleb-norrhœa are due to the gonococcus. for diplococci, pneumococci and streptococci may be also found. In adults pneumococci produce a typical blennorrhœa with difficulty distinguishable from a gonorrhœal conjunctivitis. Examine the secretions in all cases of conjunctivitis, bacteriologically, to avoid unpleasant trippings up and for hints on diagnosis, prognosis and treatment.

PSYCHIC DISTURBANCES APPEARING DURING TREATMENT WITH IODOFORM.—Dr. Schlesinger states that iodoform may determine not only certain psychic symptoms, but also certain well-characterized mental diseases. The former may be prodromal signs of the latter. The anxious restlessness, the motor excitement, the distortion of received sensory impressions, with almost free sensorium, belong to first group. The most frequent mental diseases are hallucinatory confusion of mind, which bears no specific form as well as melancholia. A comatose complex of symptoms may be observed which is associated with meningitic symptoms, and finally, in children, a peculiar state, which is a transition between the hallucinatory confusion and the comatose form.—*Deutsche Medicinische Wochenschrift*, No. 18, 1898. No drug produces a better picture of tubercular meningitis than iodoform. Several cures have been reported from its local use as a salve to the head and internally; I employed it at a late stage in one case with only a temporarily sedative effect.

FRANK H. PRITCHARD, M.D.

EXPERIMENTAL INVESTIGATIONS ON ASEPSIS IN LAPAROTOMY.—Schaeffer found that in taking cultures in Petri's dishes in the operating room it was necessary to have a double layer of filter-paper in the upper glass to absorb the water of condensation, which otherwise would drip on the cultures and spoil them. Formalin gas was tested carefully and found of little practical value, as a few drops of water will prevent disinfection of substances beneath them. The odor of formalin is very objectionable and it is necessary to spray the room with ammonia, and airing the room with an open window permits the entrance of dust and germs. Schlossman ascribes the failure of Sehering's formalin-lamp to the formation of paraformal, which is an indifferent body. He describes a new method of atomizing formalin mixed with glycerin, and claims that all bacteria are destroyed by it in three hours, but the writer made no control experiments with it, as the apparatus is not yet in the market. Formalin gas has little effect on dry objects, so that neither dry nor very wet floors can be sterilized by it. The effect of steaming the air and moistening the walls of the room to settle the dust was then tried. Slight steaming increased the deposit of germs, but very thorough steaming for two hours diminished the number of germs; but the saturation of the atmosphere in the latter case produced very profuse perspiration. Artificial rain was next tried by attaching a number of atomizers to the water-pipes. The room was very thoroughly sprayed with these atomizers for ten minutes. An examination of the air two hours later showed very marked diminution of germs, it being nearly free from them. The expired air is free from germs. Speech is more dangerous, as particles of saliva may be discharged into the air. Mikuliez examined forty-eight healthy mouths and found in one-third of them the staphylococcus aureus in full virulence. An excellent protection from this source of infection is a gauze muffler wound around the face and neck. Particles from the hair and beard are also known to convey infection, and in addition to the gauze muffler many gynæcologists wear sterilized linen caps. Drops of perspiration falling into the wound are also a source of danger. The best protection consists in thorough washing of the skin and having a nurse wipe the forehead and face. Contact infection is far more dangerous than air infection. Direct contact with unclean hands rubs the germs, as it were, direct into the wound, and not single germs but entire colonies are thus introduced. Germs from the air may collect on dry instruments, and the presence of any blood on the latter leads to the collection of bacteria to an extraordinary degree. The instruments should lie in a weak antiseptic solution, as 1 or 2 per cent. of carbolic acid, and the scalpels, scissors and needles in alcohol. Sterile towels or dressings should be covered and exposed as little as possible during an operation. The silk, after boiling, should be kept in a weak antiseptic solution, and any silk once touched with the hands should be boiled before using again. The bowl containing the silk during an operation should be covered to keep out dust, and the neck and stoppers of the containers should be protected with glass covers to keep dust from the mouths of the bottles. Operation gloves are unnecessary. The following method of disinfection of the field of operation in laparotomy is recommended. Two full hot baths on the first and second days before the operation, and shaving the pubis and abdomen before the last bath. A compress of a 1 per cent. solution of formalin for twenty-four hours; thorough disinfection of the abdomen of the patient,

thorax, thighs, flanks, pubic region, and covering the body of the patient with a fresh-boiled sheet with a slit in it corresponding to the linea alba.—*Monatsschrift für Geburtshülfe. Gynäkologie*, Bd. viii., H. 3, Sept., 1898.

REPORT ON SIX HUNDRED LAPAROTOMIES.—Rasthorn reports these cases, excluding the vaginal, from six years' work in Prague clinic. The few deaths from ileus and secondary hæmorrhage is surprising. Ileus is avoided by moist asepsis, no eventration or contact with the intestines, which are carefully protected by compresses. All sub-peritoneal wounds are covered and peritoneal wounds sewed together. The abdominal incision is as short as possible, and the Trendelenburg position used. The large omentum is drawn down over the intestines after the operation. No compressive dressing is used, and peristalsis is excited in forty-eight hours by enemata. There was one death from ileus in five weeks, from adhesion of the omentum. Another case recovered by secondary laparotomy and separating a string of adherent omentum. Secondary hæmorrhage is guarded against by ligature *en masse* and separate ligation of the vessels in the stump. Catgut is used for intra-peritoneal work prepared by ether, alcohol and sublimate. Drainage is limited as much as possible. The peritonæum, fascia and skin of the wound are united in separate layers by the continuous suture. No binder is used in uncomplicated cases, but adhesive plaster instead. Transfusions of salt solution are used before and after operation in anæmic cases. The entire mortality was 8.3 per cent., with no deaths for the one hundred cases. There were seventy-seven myomatomies, with only one death from embolus.—*Prager Zeitschrift für Heilkunde*, 1898, Hft. 2 and 3.

A RARE ANOMALY OF THE URETER IN RELATION TO A FIBROID TUMOR.—Riehl relates a very rare case of vaginal hysterectomy for multiple fibroids of the uterus in which the right ureter passed three inches directly through an intraligamentary fibroid. At the site he found the tumor adherent and discovered a string like a blood-vessel, and on careful examination it proved to be the ureter. The posterior entrance of the ureter was then located and the vessel carefully dissected out. He thinks a number of small fibroid tumors grew like a chain around the ureter and later united to form one growth. He advises, like Landorn, to avoid danger in such complications by peeling the bladder high up and away from the sides, on the broad ligaments, so that both the bladder and pars vesicalis of the ureters are well separated from the uterus or tumors and pushed up out of the way. The ureters can then be pushed aside or traced upwards when desirable. Experience has shown there is no permanent injury and no danger from such a procedure, while it insures protection to the ureters.—*Centralblatt für Gynäkologie*, No. 39, 1898.

THE BACTERIOLOGY OF PUERPERAL INFECTION.—Strückmann observed a case of staphylococcus pyæmia following an abortion. Bacteria of putrefaction were found in the large intestine, but only staphylococci were found in all the other organs. The general opinion that the staphylococcus is answerable for the more severe and especially septic processes associated with puerperal fever is not confirmed by Strückmann or Krönig, as either pure or mixed infection with the staphylococcus may lead to a mild form of the disease. The bacterium coli is being recognized gradually as a not uncommon cause of infection.—*Centralblatt für Gynäkologie*, No. 36, 1898.



**VAGINAL CÆSARIAN SECTION.**—Schanta reports a case of a woman eight months pregnant suffering from epithelioma of the cervix the size of an apple and the surrounding tissues free from the disease. The cancer was removed with the sharp spoon, an incision made around the cervix, the bladder separated and the peritonæum opened posteriorly. The broad ligaments were ligated on each side and the large vessels secured. The cervix was next removed, to avoid infection, without much hæmorrhage. The uterine walls were divided anteriorly and posteriorly high up, to allow the hand to be introduced and the child turned and delivered. The section of the uterus was then continued till the uterus came out in halves; and finally the remainder of the broad ligament on either side was ligated, divided, and the entire uterus was removed. The critical moment during the operation was the section of the uterus when the hæmorrhage was severe. Schanta advises not to divide both the posterior and anterior walls of the uterus, as the anterior is sufficient, and the cut edges can be compressed by forceps and drawn down, as there is no hæmorrhage with firm traction. The placenta should not be separated, as it protects a large surface from hæmorrhage and offers no obstacle to the removal of the uterus.—*Ibid.*

**THE BACTERIOLOGY OF THE VAGINA IN PREGNANCY.**—Kottman examined the vaginal secretion of twenty-seven pregnant women, using a method patterned after Walthard's method of aspiration from the cervical canal.

The secretion was obtained from women who had not been examined and a number of non-motile and motile bacilli were obtained, both æerob and anæerob. The streptococci differed from the streptococci of puerperal fever only by the degree of virulence which is not originally present, as has been discovered by Walthard. The vaginal secretion cannot be divided into normal or pathological classes by either macroscopic or microscopic examination, as pathological germs are found in cases where all the conditions present indicate a healthy vagina. Neither the condition of the vagina, the secretion or the results of cultures permit a prognosis as to the cause of the puerperal state.—*Archiv für Gynäkologie*, Bd. lv., H. 3, 1898.

**A NEW REMEDY FOR FIBROIDS.**—Eckstein reports good results in treating twenty-three cases by combining Fritsch's pills with Bland's pills, as follows:

R Ferri sulph.

Natri bicarb., aa 5.0.

Ergotini.

Extr. hydr. canad.

Fl. extr. gossypii, aa 2.0.

Extr. rad. acori q. s. us f. pill L.DS.

Sig. Three pills three times a day.—*Prager Med. Wochenschrift*, 1898, No. 21-23.

**THE FUNDAL SECTION IN THE CONSERVATIVE CÆSARIAN SECTION.**—Riedinger reports successful cases in Brunn. The patients made unusually good recoveries nursing their children after the tenth day. The advantages of this incision are, the small amount of bleeding, as the placenta is seldom in the line of incision; the rapid diminution of the incision and very few sutures necessary, and consequently easy control of hæmorrhage; and, finally, the easy extraction of the child, as the feet usually present in the incision.—*Centralblatt für Gynäkologie*, No. 29, 1898.

GEORGE R. SOUTHWICK, M.D.

**A FEW OTOLOGICAL DON'TS.**—Dr. N. S. Roberts, of New York (*Medical Record*), makes the following practical remarks on the treatment of aural affections. Don't treat earache with chloroform, laudanum or camphorated oil. They are inefficient and may excite local inflammation. It is better to fill the ear with hot water, with or without glycerin, apply a poultice, and, if pain persist, apply a leech to the tragus.

Don't advise or permit a patient with profuse otorrhœa to constantly wear cotton in the ear; it causes retention of the discharge, and operates against that diligent attention to cleansing and other treatment which would otherwise be given.

Don't use the galvano cautery in the auditory canal; it is liable to be followed by such consequences as necrosis, ulceration, otitis externa, or stenosis.

Don't blow insoluble powders into the ear when there is a purulent discharge through a small perforation. It may stop the discharge, but it does so usually by occluding the perforation, and may be followed by worse conditions.

Don't neglect to look for ear complications in all eruptive fevers, typhoid fever, diphtheria, and low types of pneumonia.

Don't politzerize through noses in which there is stored up foul catarrhal mucus.

Don't politzerize with much force in sensitive patients, or those having a thin, translucent drum membrane.

Don't neglect to keep watch of the mastoid prominence in all cases of purulent otitis, and if tenderness, heat and swelling are found, to take measures to subdue a probable incipient mastoiditis.

Don't overlook in chronic ear disease constitutional conditions, such as lithiasis, scorbutus, tuberculosis and syphilis. This precaution applies likewise to diseases of the nose and throat.

**EXOPTHALMIC GOITRE IN CHILDREN.**—Exophthalmic goitre in children is rare. The development of the disease when present proceeds more rapidly, the tachycardia is much less marked, the subjective sensation of palpitation is less conspicuous, the thyroid affections are constantly present, while the exophthalmic signs are confined to a relatively small proportion of cases. If all patients with chorea were carefully examined more cases of exophthalmic goitre would be found than is commonly supposed.—*Pediatrics*, vol. iv., No. 12.

**REMARKS OF RHEUMATIC AND GOUTY AFFECTIONS OF THE THROAT.**—In the rheumatic affections of the throat the writer has been unable to observe any characteristic features. In the larynx there seems to be a tendency to affect the crico-arytenoid joint, and though the swelling may not be apparent, the movements of the corresponding vocal cord are impaired and more or less permanent fixation is liable to result.

Gouty affections of the throat are more commonly encountered. These may be acute, causing pain, odynphagia, and various inflammatory manifestations, or chronic, causing tickling of the lateral walls of the pharynx, a sense of pain of a darting character, and shooting up to the ears, irritating cough, and some external tenderness about the larynx. Small tophi have been observed in the larynx and deposits have been found in the pharynx.—P. W. Williams, *Laryngoscope*, April, 1898.

WM. SPENCER, M.D.

## MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND  
THERAPEUTICS.

SOME LITTLE-UNDERSTOOD HEMOLYTICS.—Blackley, of London, after discussing the effects of iron, arsenic, lead, phosphorus and mercury upon the blood, refers to a large class containing many dissimilar substances, as "hemolytics" *par excellence*. With very few exceptions, the chief of which are the alkaline chlorates, they are organic in origin, and most contain nitrogen, either feebly united in the shape of nitrites, such as nitro-glycerin and nitrite of amyl, or in the more stable bodies of the ammonia type, such as aniline and its derivatives, nitro-benzol, trimethylamin, anti-febrin, phenacetin, etc., etc. A few are hydrocarbons, like naphthol, pyrogallol, etc. They resemble each other so far that when absorbed into the circulation they cause the appearance of methemoglobin in the blood, with more or less cyanosis as the result thereof. Their primary effect upon the blood is violently destructive, for they cause a breaking up of the red corpuscles, but they also appear to act by diminishing the power of combining with oxygen in the hæmoglobin. As these effects are chemical rather than dynamic in character, they are perhaps of doubtful value from the therapist's point of view, but the observations of several modern hæmotologists on cases of poisoning by various drugs of this class go to show that there are dynamic as well as destructive effects produced by most of them. In slow poisoning by chlorate of potash, for instance, there is to be found a gradual diminution of red corpuscles and increase of leucocytes. In a case lasting seven days, Brandenburg found the red corpuscles diminish gradually from 4.3 to 1.6 millions per cubic mm. In another case, reported by Jacob, the white cells rose on the first day to 80,000, but fell to 14,000 before death on the sixth day. On the fifth day the red cells were 2,200,000, and the hæmoglobin 20 per cent.

Cases of nitro-benzol poisoning are tolerably frequent of late years, owing to its use in the preparation of aniline and its derivatives. Most of these poisonings, being acute, show merely the destructive action upon the blood, but a case of slow intoxication recorded by Ehrlich and Lindenthal is much more instructive. Cyanosis from the presence of methæmoglobin in the blood was present throughout. Microscopic examination of the blood during the first two days showed nothing abnormal. On the third day striking variation in the size and shape of the red cells was found, with occasional nucleated normoblasts and some leucocytosis. During the next few days poikilocytosis increased, numerous megaloblasts were found, and the number of normoblasts rose—the total number of nucleated to normal red cells rising as high as 1 to 56; the leucocytes increased until the proportion on the thirteenth day was as 1 to 18. The character of the leucomia was suggestive of



a myelogenous origin. At death the red cells were much below the normal, and the anæmia was pronounced. After death, fatty degeneration of heart, liver and kidneys was found.

In a fatal case of phenacetin-poisoning, where five grammes were taken at a single dose, there was found marked leucocytosis (polymorphonuclear), with great variety in size and shape of red corpuscles. In some the hæmoglobin was broken up into fragments, in others it formed merely a marginal ring, whilst others were emptied completely.

Acetyl phenyl-hydrazine is interesting from the fact that in addition to causing profound alteration in the figured elements of the blood, it diminishes both the density and alkalinity, but augments the coagulability of the blood.

What the exact future of this class of bodies may be as therapeutic agents remains yet to be determined. The writer's only serious experience is limited to the use of toluylendiamin in a case of hæmoglobinuria. After many weeks of steady treatment the patient left the hospital practically *in statu quo*.—*Journal of the Brit. Hom. Soc.*, July, 1898.

VERATRUM VIRIDE FOR STREPTOCOCCIC INFECTION. After dwelling upon the wide fluctuations of temperature which are characteristic of veratrum viride, Cartier, of Paris, reports some observations confirming the communications of Dr. Richard Hughes, Dr. Ludlum, and of an allopathic physician, Dr. John Brow, on puerperal fever, a malady with an essentially fluctuating temperature; on cases of cellulitis, of phlegmonous erysipelas, of pelvic suppurations, cited by other authors, all of which are accompanied more or less, as were the cases from his own practice, by fluctuations of temperature. These fluctuations most often indicate an acute septicæmia or threatening suppuration. The microbe which most often brings on these septicæmias and suppurations, and manifests its presence by the great variations in temperature, is nearly always some one of the numerous varieties of the streptococcus. We are able to say, by deduction, that veratrum viride is one of the remedies with which we are able to oppose the streptococcic infection, though at the present moment the anti-streptococcic serum is more discussed.

Some have compared the action of veratrum viride to that of aconite. In the opinion of the writer this is an error. Aconite has no subnormal temperature, as has veratrum, nor has it the alternating heat and cold. Aconite never opposes a threatening suppuration, and he does not know much of remedies analogous to veratrum viride. Among the medicines for suppurative infection, the snake poisons—*tarantula cubensis*, *hepar*, *mercurius* and *myristica*—have, perhaps, most action on suppuration; but he does not know that any has the symptoms of febrile fluctuations so marked. That which takes the place of this remedy is surgical interference; a fluctuating curve very marked always means a suppuration on the way. When there is localization at a focus, opening the abscess causes the temperature to fall immediately; but often one suspects pus without knowing exactly where it is formed, especially when it is in the internal organs, and finally the purulent infection may become general. In conclusion, veratrum viride does not oppose suppuration, but it does exercise an action on the thermometric curve. This fact is supported by the *materia medica* and by clinical observations.—*Medical Counsellor*, August, 1898.

F. MORTIMER LAWRENCE, M.D.

FERRUM CHLORIDUM IN CHRONIC DIFFUSE NEPHRITIS.—Speaking of ferrum phosphoricum recalls to mind the great virtue I have found to exist in the old-fashioned tincture of the chloride of iron in a certain variety of Bright's disease. I have never seen any remedy act as well, as satisfactorily, nor as promptly as this in a certain form of this affection. Naturally enough the longer the disease has persisted the less are the chances for success. I have noted that these cases will be thin, possibly scrawny, generally pale, with dark rings around their eyes. I have met with other associated symptoms. Their appetites are poor, the mucosa pale, the tongues *not* much coated; there may be attacks of headache, which persist or not; there are terrible neuralgias here and there, and especially in the legs, *below the knees*. This is the only drug that I know of that has this characteristic symptom. The bowels are constipated; there is absolutely no dropsy. The pulse is hurried and feeble, though now and then an increase of tension is noted. The heart sounds indicate an abnormally high blood-pressure, for they are accentuated, and particularly that of the aortic valve. But the urine is characteristic, the sp. gr. *is very low*—1003.5-6-8-9-10; there is a great amount of albumin present. Microscopically one will find any amount of granular casts, either light or a little dark. I have met with this condition in children chiefly, and in those ranging from seventeen months to twelve years. I have also seen it in women adults and mothers of a family. I almost hesitate to call it a chronic diffuse nephritis, for it appears to be more on the interstitial order. But in this state the tinct. of the chloride of iron will do more good than any other remedy that I know of. It causes the specific gravity to creep up, the digestion to become better, the pale cheeks to take on color, the albumin to become less and less, the casts to become less numerous, and finally to disappear, until only a few epithelial masses are observed. I give it in doses of one to five drops, three or four times a day. We all know that iron acts on the blood, and that it acts as a hæmatopœtic remedy, for the old school has employed it for years here. Yet there is another and far more important point to keep in mind with regard to iron. Iron is a specific kidney remedy, and acts by virtue of its specific affinity for that organ. Therefore it acts homœopathically, and it will do wonders in a certain state. Prof. Kobert speaks of its causing toxicologically *grave changes in the kidney*. Pareira states that it possesses *some specific influence over the whole urinary apparatus*.

COLCHICUM IN CHRONIC DIARRHŒA.—Dr. Bonino, of Turin, was consulted by a tanner of 30 years, who, otherwise well, had suffered for eighteen months from a chronic diarrhœa with evacuations with a very evil odor, violent pains before each passage, especially at night. On account of the great duration of the disease and the greater frequency of the stools towards morning sulph. was given, unsuccessfully. On closer examination the discharges were found to be fluid, full of numerous mucous shreds, as though scraped from the intestines. Colch. was therefore administered (3x), which in two days restored the stools to the normal state.—*Allgemeine Homœopathische Zeitung*, July 7, 1898.—Dr. Bonino, in his work—*Primi Studi di Materia Medica*, Torino, 1893, p. 147—gives under colchicum: "Mucous, white dejections, with great tympany and tenesmus. Sanguinolent dejections with mucous shreds and flakes, as though the intestines had been scraped (brom., canth., colo.).

Lacerating pains in the anus during stool." Prof. O. Schmiedeberg, of Strassburg: *Elements de Pharmacodynamie*, p. 104—says: "Les symptômes cholériformes dominent aussi la scène toxique. A l'autopsie, la muqueuse intestinale montre assez souvent, chez l'animal, une forte rougeur, du gonflement et des ecchymoses." Burt cites Stillé, who analyzed ten cases where the tincture, seeds, infusion of the bulb and leaves were taken, in poisonous doses. There was diarrhoea in every case. The stools were frequent, liquid, greenish, or black and foetid, or containing shreds and flakes as of coagulated mucus. Thirst was by no means urgent; in one case the tongue was blue and cold.

**TREATMENT OF PERNICIOUS ANÆMIA.**—Dr. Olivé, of Barcelona, thinks ferrum homœopathic to anæmias but not to all cases, it acting by its influence upon the nerve centres. The best preparation is ferrum phos. Ferrum carb. is of service when there is "pyrosis without neuralgias." Ferr. muriat. when there are eructations with a feeling of emptiness in the stomach, without constipation or vomiting. Ferrum citric. in the paralytic states of chlorosis, with loss of appetite and vomiting of food. Ferrum met. if there be no digestive troubles. He also recommends several other remedies which have given him good results. Calc. carb. 3x or 30x when there is amenorrhœa or menses too early, leucorrhœa, headache, gastric symptoms, especially in pale women who are fleshy and of a vivacious and irritable character. Phos. 6x in nervous weakness and fatty degeneration of the heart. Arsen. 3x in grave cases; natr. mur., puls., china, ignat., kali phos., cupr. met., cyclamen, nux, sulph., graphites, sepia, conium and lycop., according to their symptoms.—*Journal Belge D'Homœopathie*, No. 3, Vol. v., 1898.

**CHINA IN ASCITES OF HEPATIC ORIGIN.**—Dr. Bonio was consulted by a woman of 40 years, mother of four children, who several years before had an exudative pleuritis which had been tapped. In 1891 ascites appeared, in consequence of a liver disease which was removed by china. In June, 1897, she again appeared with ascites, œdema of the lower extremities, scanty and turbid urine, occasional vomiting of a bitter fluid in the morning. Her heart was normal and her periods tolerably profuse. Apocynum cann. increased and cleared up her urine, but the ascites would not yield, and therefore china was again given (3x), and this remedy, continued for two months, brought a restoration to health.—*Allgemeine Homœopathische Zeitung*, Nos. 1 and 2, Bd. 137, 1898.

**CIMICIFUGA IN NOISES IN THE EARS.**—Drs. Albert Robin and Mendel, of Paris, recently communicated nine cases of tinnitus aurium where cimicifuga did good service in its treatment. In terminating they conclude that: 1. Roaring and buzzing noises in the ears may be considered as a reaction of the auditory nerve, irritated either directly or reflexly. 2. Cimicifuga racemosa acts upon the auditory circulation and reflex irritability of the ear-nerve. The active median dose is thirty drops of the fluid extract per diem, though they usually begin with fifteen drops, and increase the dose to thirty in a day. Successful results are usually obtained in two or three days after treatment, though some cases react much more slowly. 3. Tinnitus, which has lasted more than two years, is influenced with difficulty by this drug.—*L'Art Medical*, No. 7, 1898. FRANK H. PRITCHARD, M D.



# THE HAHNEMANNIAN MONTHLY.

---

DECEMBER, 1898.

---

## COMPARATIVE STRENGTH OF TINCTURES.

BY J. WILKINSON CLAPP, M.D., BOSTON, MASS.

(Read before the Massachusetts Homœopathic Medical Society, Wednesday, Oct. 12, 1898.)

THE desirability of securing uniformity of methods in the preparation of homœopathic tinctures has long been recognized. As early as 1868 the American Institute of Homœopathy appointed a special committee, with Dr. Carroll Dunham as chairman, to prepare a Dispensatory which should embrace pharmacy. This committee was engaged in the preparation of such a work eight years, the death of Dr. Dunham preventing its completion. The results of the labors of this committee were not made available.

In 1886, and again in 1887, special committees were appointed by the Institute to consider the question of publishing a pharmacopœia. Both of them reported in favor of taking such action, and both advised that the *British Homœopathic Pharmacopœia* be made the basis. The reason for such recommendation was that the English tincture-making process secured uniformity of strength and gave a definite and well-defined unit of strength as a starting-point for attenuation. As a result of the reports and recommendations of these committees, the Institute, in 1888, appointed a committee of twelve

members, six of whom were pharmacists and six physicians, selected with special reference to their fitness for the work assigned them, they being recognized students of materia medica, chemistry and pharmacy. This committee was instructed to prepare a pharmacopœia, and to take the *British Homœopathic Pharmacopœia* as a basis.

After nine years of labor the work has been completed and has received the full endorsement of the Institute, the medical press, and such members of the profession as are qualified to judge of its merits. Of the twenty-four homœopathic pharmacists in the United States ten have adopted it as their sole standard, while others use it in connection with other pharmacopœias. It is to be regretted that certain other pharmacists have assumed a hostile attitude toward the work, and have sought by misrepresentation to prejudice the profession against it. While not a single scientific objection has been raised against any portion of the new pharmacopœia, much has been written and said to grossly misrepresent it, more especially as regards the strength of tinctures resulting from its use.

It is not my purpose here to reply to these statements, but to call your attention to a few facts relative to the strength of tinctures made in accordance with—

First, The rules of the *Pharmacopœia of the American Institute*.

Second, Hahnemann's original directions.

Third, The rules of other pharmacopœias at present in use; also, to call your attention to the designation of drug-strength as given by these different authorities.

The American Institute has adopted the English system for making tinctures, as it secures uniformity in preparation as well as in strength. Under the so-called English system the dry crude drug is made the unit of strength—in other words, the starting-point from which to estimate strength. From this it should not be inferred that all tinctures are made from dried plants, etc. On the contrary, the fresh green substances are used whenever possible, and the moisture contained therein is used and considered part of the menstruum. With very few exceptions, tinctures are made to represent one part, by weight, of the dry crude drug in ten parts, by measure, of the tincture, and, as a result, in many instances the tinctures actually contain all the soluble constituents of more than 50 per cent. of

the fresh, succulent plant. As, for example, belladonna, which contains 667 parts plant and 470 parts alcohol. It should be understood that a tincture is a simple solution of the soluble constituents of drugs, and that its strength is limited to its point of saturation. It differs from a fluid extract in that the latter is made much stronger by concentration or supersaturation. Drugs vary much in degree of saturation, and it has been found that in the preparation of tinctures the proportion of 1 to 10 is the strongest it is expedient to use, as the majority of drugs cannot be exhausted with a much less quantity of menstruum, and many require even more than this amount. Jahr, who certainly will be recognized as one of the best of homœopathic authorities, considered 1 to 20 a better proportion, and so directed in his pharmacopœia. On page 30 of Jahr's *Pharmacopœia and Posology* we find the following:

"As to the proportion in which alcohol ought to be added, many physicians have proposed to make it 1 to 10, instead of 1 to 20—that is to say, to pour but 10 parts of alcohol on the pulverized substance; but independent of the certainty there is in the proportion of 1 to 20, the vehicle will necessarily take up all the medicinal virtues, and the tincture of many substances, as cinchona, opium, ratanhia, etc., seem to be in this proportion so fully saturated that it is very doubtful whether, in the proportion of 1 to 10, they would really acquire more energy."

Quin's *Pharmacopœia*, once a standard homœopathic authority, requires the same proportion, and the *Pharmacopée Homœopathique Française*, of France, published the present year, adopts the proportion of 1–20.

The rules of the *Pharmacopœia of the American Institute* are such as to secure, with but few exceptions, tinctures representing one part of crude drug to ten parts of menstruum, and the strength is so indicated,  $\psi\text{--}\frac{1}{10}$ . This makes the crude drug in each case the unit of strength. Such a system enables us to make our dilutions and our triturations correspond in strength. To illustrate: The 3x trituration of nux vomica contains in each grain  $\frac{1}{1000}$  grain of the pulverized drug, and the 3x dilution represents in each minim  $\frac{1}{1000}$  grain of the crude drug.

Is it not easy to comprehend the great advantages gained by



this method of designating the strength since it gives us a unit always of the same value, thus securing uniformity and enabling us to know the exact drug-strength of all attenuations? For example, the sign 2x will always indicate  $\frac{1}{100}$  grain crude drug whether in solution, dilution or trituration.

Hahnemann directed that tinctures to be prepared from dried substances should be made in the proportion of 1 part drug to 10 parts alcohol. It will be observed, therefore, that this class of Hahnemann's tinctures are the same in strength as those made by the rules of the Institute *Pharmacopœia*.

Hahnemann directed that tinctures from green succulent plants containing large quantities of moisture should be prepared with equal parts of the juice and strong alcohol. Now, as most succulent plants contain upwards of 80 per cent. of moisture, it is clear that the amount of menstruum used, consisting of the alcohol and plant juice, will equal a larger proportion than 1 to 10. Further, in this class of tinctures he did not provide for macerating the plants, but only for using the expressed juice. As a result, this class of tinctures, representing about  $\frac{1}{12}$  of the entire list, are much stronger if made according to the rules of the Institute *Pharmacopœia*. The result of analysis may best indicate this. Tinctures of aconite and belladonna made with equal parts alcohol and fresh plant, by expression and by maceration, show the following result by analysis:

Aconite $\phi$ contains :					By Expression.	By Maceration.
					Per cent.	Per cent.
Dry residue.	.	.	.	.	3.38	4.84
Alkaloids,	.	.	.	.	.03944	.07142
Specific gravity,	.	.	.	.	.9543	.9885
Belladonna $\phi$ contains :						
Dry residue,	.	.	.	.	2.32	3.27
Alkaloids,	.	.	.	.	.04335	.06703
Specific gravity,	.	.	.	.	.9513	.9729

This evidence should be conclusive and prove beyond contradiction the superior strength gained by the employment of the English method as set forth in the *Pharmacopœia of the American Institute of Homœopathy*.

The larger class of Hahnemann's tinctures, from fresh green plants, roots, etc., he directed to be made in the proportion of 1 part drug to 6 parts alcohol. As but few medicinal plants

contain less than 50 per cent. of moisture, it will be noted that this is in greater proportion even than 1 part crude drug to 10 parts liquid. It would seem, therefore, that Hahnemann endeavored to arrange his classes of tinctures so as to secure a standard of strength somewhat near this proportion. It will also be manifest that the methods employed by Hahnemann and by the *Pharmacopœia of the American Institute* do not differ, in any marked degree, in the quantity of menstruum used. It can be justifiably claimed, however, that by improved methods the strength of our preparations has been increased and that uniformity has been secured.

The rules of the British *Homœopathic Pharmacopœia* for the preparation of tinctures are essentially the same as those of the *Pharmacopœia* of the Institute; in fact, as previously stated, the Institute has adopted the English system.

Previous to the publication of the *Pharmacopœia of the American Institute*, Jahr & Gruner's *Homœopathic Pharmacopœia* was employed by a large number if not by a majority of homœopathic pharmacists in this country, and it is still recognized as authority by several of our pharmacists in good standing. The rules of this work subdivide tinctures into three classes:

1st. Those made from dried substances in the proportion of 1 to 10.

2d. Those made from fresh, succulent plants, using equal parts plant and alcohol, the tincture being prepared by the process of maceration.

3d. Those made from fresh plants containing less moisture—these in the proportion of 1 part plant to 2 parts alcohol.

It will be noted that tinctures prepared according to the first two classes will not vary essentially in strength from those made by the Institute *Pharmacopœia*.

Of the third class, where made from plants containing upwards of 75 per cent. of moisture, the resulting tinctures will be of less strength; where below 70 per cent., apparently of greater strength; but this is entirely dependent upon the nature of the plant and the quantity of menstruum necessary to exhaust it. The difference in most cases is only apparent, not real.

Finally, we will consider the strength of tinctures made ac-

cording to the rules of Schwabe's *Polyglottica Homœopathica* and the *American Homœopathic Pharmacopœia*. These works are essentially the same, the latter, as far as rules of pharmacy are concerned, being a reprint of the former. They give rules for the preparation of tinctures under four distinct heads or classes, as follows:

1st. Those made from succulent plants by use of 1 part expressed juice with equal parts of alcohol. Estimate of drug-strength,  $\frac{1}{2}$ .

2d. Also of succulent plants made with 3 parts plant to 2 parts alcohol. Estimate of drug-strength,  $\frac{1}{2}$ . This class includes but a limited number of medicines.

The rules for these two classes are based upon Hahnemann's original directions, so that what has been stated previously in relation to resulting tinctures will apply to these also.

3d. Tinctures from fresh plants by use of 1 part plant to 2 parts alcohol. Estimate of drug-strength,  $\frac{1}{3}$ .

4th. Tinctures from dried substances by the use of 1 part plant to 5 parts alcohol. Estimate of drug-strength,  $\frac{1}{10}$ .

The claim is made that the rules for the preparation of tinctures given in these pharmacopœias are taken from Hahnemann's original directions. This is far from correct, as for the preparation of tinctures corresponding with the third class he directed the use of 6 parts of alcohol to 1 of plant, and for tinctures prepared from dried substances he made the proportions 1 to 10. It would seem that Hahnemann was better versed in the laws of pharmacy than some of his successors. He knew that in the preparation of tinctures, with few exceptions, drugs cannot be exhausted with any such small proportion of menstruum. If the compilers of these pharmacopœias had but followed Hahnemann, the literature of homœopathic pharmacy would have been at least less deserving of hostile criticism.

As to the designation of strength. The tinctures of the *Pharmacopœia of the American Institute* are with but few exceptions designated as  $\psi \frac{1}{10} 1x$ , the dry crude drug being made the unit—in other words, the starting-point from which to estimate strength. Classing them as  $1x$ , first decimals, has led to misinterpretation, and also to much in the way of misrepresentation. Still, this is the only system indicating plainly the exact drug strength of our attenuations. The absurdity of the system of



Schwabe and the *American Homœopathic Pharmacopœia* is shown by comparison.

A tincture containing equal parts juice and alcohol is designated as having a drug-strength of  $\frac{1}{2} = 50$  per cent., the water present being included as part of the drug-strength. It would more correctly be designated at  $\frac{1}{33} = 3$  per cent. While a tincture made with 1 part dry crude drug to 5 parts alcohol is classed as having a drug-strength of but  $\frac{1}{10} = 10$  per cent., this, if fully exhausted by the menstruum, would possess a strength of  $\frac{1}{5} = 20$  per cent.

By this system a tincture possessing less than half the strength of one made according to the Institute *Pharmacopœia* is designated as five times as strong.

The Committee on Pharmacopœia of the American Institute of Homœopathy has issued its work with the conviction that homœopathy has advanced to that stage which will warrant the application of scientific rules to its methods in pharmacy. Is not the homœopathic profession ready to approve this action and give it its support?

---

## THE SANATORY TREATMENT OF MELANCHOLIA AND NEURASTHENIA.

BY ROBERT WALTER, M.D., WALTER'S PARK, PA.

(Read before the Homœopathic Medical Society, State of Pa., Pittsburgh, Sept., 1896.)

My experience with these ailments began with personal invalidism more than forty years ago. At that time, after some years of experiment, I was abandoned by the profession as hopelessly incurable with insomnia, nervousness, great debility, generally referred to an organic disease of the heart as the immediate cause. Soon afterward it was my fortune, good or bad, as you choose, to be engaged in observing the operation of processes employed for the relief of invalids, of which I was one, whose complaints were chiefly nervous weaknesses. For several years one hundred or more cases, in varied stages of development, were daily before me, so that I had rare opportunities for forming conclusions, both as to the nature of the ailments and the value of the methods employed for their cure. One of the most important of these conclusions was

that if prevailing methods by tonics, stimulants, and nervines were continued much longer the profession would reap a rich harvest of nervous diseases, corresponding to the harvest of blood and bowel diseases it had unwittingly secured through bleeding and purging. We have not been disappointed. Hahnemann taught the same truth. What cures disease is capable of producing them; what produces diseases may, when properly administered, cure them. The alarming increase of nervous diseases is a fact about which there can be no dispute. One of the most interesting of all questions to the physician is:

*How Best to Prevent and Cure Them.* The old German physician's advice to the importunate invalid, who insisted upon a prescription from him, is clearly applicable here. "Do different, sir; do different." Remove the cause and the effect will cease. It was Hahnemann who taught that vital force performs the functions of the organism in both health and disease, and that disease is simply disturbed vital action. The human machine was made to run successfully, pleasantly, easily, and will continue to do so if occasions for deranged action are not suffered. These occasions for deranged, perverted or deficient action may be summed up in two words, obstruction and exhaustion. Melancholia, we shall see, is dependent chiefly upon the former, while neurasthenia represents, in addition, exhaustion of the nervous forces. But in all cases obstruction is a necessary element of disease, no matter what the form.

What do we mean by obstruction? We mean that the materials introduced into the organism have not been properly changed into blood and tissue and the resulting elements have not been eliminated. The ingesta has exceeded the egesta. The consequence is that the vital organs are overburdened with materials they cannot use, the circulation engaged in transporting these materials is correspondingly impeded, nutrition substantially suspended, and excretion reduced to a very low margin. Is it any wonder that the patient should be depressed in mind?—all his functions are depressed. No wonder that he becomes weak and worried, timid and sleepless; the sustaining power has been withdrawn.

The source and cause of these obstructions is a matter of

great importance. The air we breathe, the fluid we drink, and the food we eat, yield to the living organism all materials, and whether these materials shall obstruct or facilitate vital processes depends entirely upon the ability of the organism to use them. Air and water are diluents, cleansers, vehicles of transportation, the great natural agents for removing obstructions; we cannot easily have too much of them if they are pure. It is food that supplies the solid materials for organization, and when used in excess becomes the source of vital obstruction. The quantity eaten should correspond to the ability of the organism to change, appropriate and finally excrete it. What mouth and nose take in, lungs, skin, kidneys, bowels must cast out. The capacity is limited in all cases; it were well if physicians could appreciate these limitations. What the system can appropriate should be supplied; what it cannot use should be withheld. To every man according to his capacity is the rule; to exceed that capacity is to threaten its extinction. Let the prayer of Agur be ours: "Give me food convenient for me."

Food differs from air and water in that it is a complex substance that must be disintegrated and undergo varied changes in the organism before it can be of any service in sustaining life or building up vital organs. It is not simply required of it that it shall be digested, as some seem to think; it must be assimilated, purified, excreted as well. Nine-tenths of the responsibilities of physical life circle around what we eat and drink, and this responsibility has only fairly begun when the food has been digested. It is food which involves the great complexity of organic structure which the animal organism exhibits; it is food that necessitates the existence of stomach, liver, bowels, even of lungs, kidneys and skin. How much work these organs do depends upon how much food one eats or drinks. *The more food, the more work*; in these days of prostrations, exhaustion and want of rest, it were well to emphasize this great truth.

We have thus suggested, in short phrase and in general terms, the sources of the obstructions which lie at the root of all forms of melancholia, neurasthenia, nervous prostration, and, indeed, most other diseases. Let us now, for a few moments, particularize. The great source of organization, devel-



opment and physical vigor is well described by the term nutrition. Nutrition, as the physiologists tell us, is a process of life which takes place in the capillary circulation. It is a great mistake to confound it with food. Instead, it is the process of building the prepared materials into vital structure. But there are two systems of capillary circulation which are complementary to each other. These are, first, the capillaries of the general system, through which all organs are built up; and, second, the capillaries of liver, lungs, bowels, kidneys, skin, in which the opposite processes of disintegration and elimination occur. Through the one set of capillaries the blood is changed from arterial to venous; that is, blood of high quality falls to a lower level in order that the tissues of the part through which it passes may gain what the blood loses. In the other set of capillaries, those of liver, lungs, kidneys, bowels, etc., the blood regains what it had lost while the worn-out particles are taken up and excreted. These excretions are the egesta, which should correspond in general terms with the ingesta—the air, water and food. The peculiar and important fact here to be noted is, that unless these changes are effected in greater or less perfection in their respective organs, the blood cannot pass through them, the circulation is obstructed, nutrition suspended, and, if the stagnation be complete, death is the result. Thus, if the blood cannot be oxygenated in the lungs, circulation cannot continue, but death follows, as from hanging, or the heart failure of pneumonia. If the liver cannot secrete the bile from the blood, congestion and enlargement follow, and the whole portal system becomes overburdened. If the kidneys fail to secrete urea in proper measure, as in Bright's disease, circulation is obstructed, and valvular insufficiency may be expected. So, too, if the nutritive changes cannot be effected in the general capillary circulation, the flow of blood is greatly impeded, the labor of the heart is correspondingly increased, and vital exhaustion threatened, both from reduced nutrition and increased labor. Shall we administer more food under the insane idea that food is nutrition, that it gives strength? Shall we give heart tonics to increase the vigor of the pressure upon the already overburdened organs? Shall we administer stimulants whereby to support the patient's strength and compel the heart to pump against an immovable

barrier to circulation and health? The insanity of such practice ought to be evident to every reflecting mind. Under such treatment and such conditions is it wonderful that the patient should be afflicted with gloomy forebodings, restless anxieties, irritable temper, delusions, insomnia, nervous weakness, or, indeed, any other disturbance of mental or bodily function? Too often the mind itself becomes unbalanced, as the rapidly increasing number of inmates of insane hospitals testify. Will differential diagnosis come in here to tell us whether it is neurasthenia, melancholia, nerve exhaustion, prostration, or what? Our object is not so much scientific nomenclature, or even correct diagnosis, as it is to indicate a system of treatment based upon the ideas advanced which has proved in our hands remarkably successful.

Two leading thoughts underlie this treatment. First, Cease to introduce the obstructions. Second, Apply treatment to quicken circulation, and thereby increase both nutrition and excretion. The first is accomplished by withholding all food for 48 to 72 hours; the second indicates the importance of massage, fomentations, baths, with abundance of pure air and pure water as the agents of circulation and excretion. By withholding food, stomach, liver, lungs, heart, kidneys, skin are all rested, and given time and opportunity to "catch up with their work," using a popular phrase. Think of 72 hours of breathing, secretion and excretion, while as yet no new material is introduced for the vital organs to work upon. But the patient will be exhausted, you say. On the contrary, the nutrition, through which all strength and vigor come, will be quickened, and immediate relief in many cases be secured. By this means we obtain all the benefits formerly secured by bleeding without any of its injurious consequences. True, the patient may temporarily miss the sustaining power of being crammed, but man is something better than an empty bag which cannot stand alone. We have taken many cases of invalids as weak as crying babies, and with a little fast given them the courage and the resolution of the man behind the gun—of the free-born American. "It is written that man shall not live by bread alone." The power of manhood is from a nobler source than bread and beans.

The value of massage in these cases is not to be despised,

though we seldom employ it until after the fast has ceased. Twenty-five years ago we began its employment in our Sanitarium, and have always found it one of the most important measures in the treatment of chronic invalids of all kinds. But, we must warn you of a great error in its employment; it is generally used to excess. No invalid can be benefited by a massage continued longer than thirty minutes if properly given. You can't work power *into* an invalid, but you can easily work it out. "Enough is a feast" is just as true of exercise as it is of food. And massage is exercise administered by the hand of the attendant. It means manipulation, pressing, squeezing of the soft tissues of the body in such way as to facilitate the passage of the blood through the capillary vessels and so promote nutrition of the parts. Hot fomentations applied over stomach and liver to warm up these great organs of sympathy, and so warm the whole body, is often very valuable. But, more important than all, in many cases the bowels should be thoroughly washed out. We commend to the attention of all those who imagine that a man can't be clean without a daily bath the thought that cleanliness within is fourfold more important than cleanliness without. If the smooth external skin cannot clean itself, but needs frequent washing to prevent impurities from being reabsorbed, what shall we say of the irregular mucous-membrane of the bowels, that great organ of absorption, with its numerous folds, creases, pockets, all crowded full in many cases with the foulest of matters. What creatures of habit we are! We have become accustomed to the thought of the cold morning bath, which has not a single sound argument in its favor, while we overlook the reeking foulness of an inactive if not impacted colon. A few years ago a patient came to us suffering with a syphilitic ulcer of the soft palate, which was well-nigh eaten up. We questioned him as to his habits, and found them very correct, even to the daily movement of his bowels, but upon investigation found the abdomen distended with fecal matter, which, when we removed, the ulcer healed in a few days, and that was the end of it. A thorough washing-out of the bowels by the injection of three quarts of warm water in which a little boracic acid may be dissolved, is an important measure in the treatment of most cases. A few years ago a leading business man of the city of



Baltimore, nearly seventy years of age, was brought to me suffering from what his brother, a leading physician of that city, had told me was unquestionably "softening of the brain," but with injections, abdominal kneadings, diet and massage, was entirely restored in four months, and returned to his business, which he still continues.

But a more systematic statement of a few of the cases treated will perhaps be appreciated. Some few years ago Mrs. E., a widow, age about fifty, was brought to our Sanitarium by Dr. S. G. A. Brown, of Shippensburg, Pa. The case was a very forbidding one, having passed almost to a state of dementia, so that we demurred to receiving her, but at the earnest solicitation of the doctor finally consented, and put her in care of a nurse, who was instructed to stay with her and simply see that she did herself no harm. We think the patient was so far gone that she did not know what we did for her. Her bowels being regular we did nothing for three days but let her live on air and water, with an occasional dose of arsenicum 30x to quiet her restlessness. At the end of this time we packed her in blankets wrung out of hot water, and three hours afterward gave her food. She was not very hungry and ate moderately. Each day thereafter she had a massage, or oil rub, or a bath, with two meals of food daily, and at the end of three weeks was entirely restored. Her daughter, who had previously been worn out with her care, came and spent a pleasant week with her, and took her home entirely recovered, and she has continued well ever since, or had when last heard from not long ago.

Soon afterward Mrs. N., the wife of a leading railroad official residing at Allentown, Pa., was brought to us by Dr. Helfrich, of that place. The record of her case, made by my then assistant, Dr. William Erwin, says, among other things: "Date of admission, October 17, 1895. Age, 50. Appetite, poor; bowels, regular. Disease, melancholia. First attack suffered twenty years ago. Had several since then, which always lasted several months." Was so nervous, irritable, sleepless, melancholy, that an insane asylum had been considered. We put her in care of a nurse; she fasted three days, followed by massage and two plain baths weekly for cleanliness, and returned to her home entirely recovered in two weeks. She has had a slight attack the past summer and returned for another two-weeks' treatment.

Case 3. A business man of Baltimore, age 46, suffering for four months, had badly hacked his throat in an attempt upon his life, just before coming under our care. At first we demurred receiving him, but after much solicitation of friends put him in care of two nurses in a cottage near the institution; kept him without food of any kind for three days; gave him all the water he wished, and after fasting, massage, moderate bathing, two meals daily for a month, he was entirely restored, and has continued well ever since.

Though these cases were generally treated without the use of medicines of any kind, it is not to be presumed that we do not use them freely in cases where they are indicated homœopathically. Incidentally, we might mention a case in which a very remarkable cure was begun by two doses of aconite 3x, and completed by massage, baths, and proper diet. This patient was recommended to us by an eminent New York allopath, who had diagnosed aortic obstruction, and was securing to him sleep by chloral and bromide in very considerable doses. On examination, he certainly had a bad heart and was extremely nervous, with slight fever. Gave him acon. 3x in the morning, and asked that he report in the evening for further examination, which he did. We soon found that a great change had taken place; temperature normal, heart's action much improved. He slept well without other drug than aconite, and was perfectly restored in about six weeks. He gave the credit of his cure to the fine air of our place, wholly ignoring the infinitesimal dose that had produced for him really wonderful results.

Mrs. J., brought to us by Dr. Isaac Johnson, of Kennett Square, Pa., author of that excellent little work, *Therapeutic Key*, came suffering from insomnia. "Oh, doctor," she cried, "unless you can get me sleep I will die." I replied, "I will get you sleep if you will do as I want you to." She would do anything. Her trouble was partly asthmatic, though she had a quite pronounced systolic murmur, which prevented her from lying down. We recommended a fast, which she took, and never afterward had any trouble about lying down or sleeping.

But a more important case was brought to us by Dr. I. N. Thayer, of Newark, N. J., who came with the patient and

remained with him during his stay under treatment. Admitted June 23, 1897. Age, 50; weight, 180; former weight, 210. For nine years had been in poor health, but for seven months had suffered agonies from rectal abscess, insomnia, delusions, most distressing irritability, which had worn out his family, from whom he was now separated, for their relief as much as his own. The abscess had been lanced, the external sphincter cut, and the internal sphincter so paralyzed as to be useless. He could not retain his feces, and had been told by good advisers that he could never hope to do so again. We demurred to the diagnosis, gave him encouragement for complete restoration, and after much persuasion finally got him to submit to treatment. The first twenty-four hours always proves the most difficult to secure. At the end of this time, upon entering the room, the patient extended his hand, and exclaimed: "Doctor, if you will stand by me I'll stand by you." The battle was won. Twenty-four hours' fast had replaced timidity with courage, obstinacy with pliancy, despair with hope, and once more the patient was a man, equipped again for the battle of life. We continued his fast forty-eight hours longer, and then, with a good wet hot blanket pack for forty minutes, which restored to him the circulation of a giant, he was ready for his dinner, and for eight weeks never murmured at being restricted to food once a day, after which he was restored to excellent health and returned to his work. The sphincter, which had been paralyzed for two months, regained its tone, and every element of his affliction disappeared. Being very fleshy, the patient had lost twenty-five pounds in weight, though the rule is that patients gain in weight as well as strength under the treatment. In addition to the strict diet, the patient was massaged daily, with baths twice a week and fomentations, oil rubs, etc., as indicated. In closing the description of this case, I wish to acknowledge my great indebtedness to Dr. I. N. Thayer for the aid he extended to me not only in carrying out the treatment, but for his unswerving fidelity to the interests of his patient.

During the summer just past numerous cases have been subjected to these measures with abundant success. We cite two typical cases. Mrs. D., the wife of a Moravian preacher, was brought to us by her brother-in-law, who had learned of



Case No. 2, above described. We found that she had had a previous attack, and had been in the insane department of the Pennsylvania Hospital, where she remained for three months, without apparent benefit. We found her sleepless, restless, melancholy, and with a delusion that she could not speak. Her age was 49, mother of four children, bowels constipated, menses irregular. We put her in care of a nurse, stopped the sleeping-powders, gave her no food for three days (she didn't care to eat), washed out the bowels thoroughly, gave hot blanket pack at the end of the fast, and thereafter food twice a day. In a week she began to respond to our suggestions, in two weeks would answer questions, in three weeks was bright, cheerful, and took interest in all that was going on. She soon returned to her home, well, since which we have not heard from her.

A more interesting case was W. S., a Philadelphia city official, who had been removed to the Johns Hopkins Hospital, Baltimore, for treatment. The physician-in-charge urged that he should by all means be taken to Walter's Sanitarium, and arrangements being completed through telephone, he reached us June 29th. On examination we found—age 63, weight 128, former weight 150, married, bowels constipated. The patient had refused to eat. He lay in a semi-stupor. When asked to show his tongue or answer questions he only murmured, "No use, no use." Was very weak, and for several weeks had been subject to extreme melancholy with insomnia. The family history in this respect was bad. We allowed the fast to continue for a day, then began with small quantities of Eskay's Albuminized Food. In a few days other food was added. At the end of the first week he suffered from retention of urine, with paralysis of right arm, which passed away in a few days. The treatment consisted of massage, or oil rub, or hand-bath daily, preceded by hot fomentations on stomach and liver for fifteen minutes, or by alternate hot and cold applications along the spine for twenty minutes. After the first week he began to appreciate the physician's visit and respond to any requests; after the second week he was able to sit up and get out on the piazza in an easy chair; in the third week he was able to move about, and began to be cheerful; at the end of the fourth week his wife, who had been his faithful companion and nurse, re-

turned home, while he continued under treatment, a cheerful, hopeful convalescent for three weeks longer, when he also returned home entirely restored.

Did we have time we might record the results in a very remarkable case of facial neuralgia, which had continued for months, the only relief being obtained through injections of cocaine. The fast, massage, two meals daily, hot and cold applications to the cervical vertebra (spigelia 200x appeared to have no effect), effected a complete cure in about six weeks. We have also secured fine results in rheumatism by the same methods in connection with the indicated remedy, which remedy had, however, completely failed when the fast was neglected. In one case of fifteen years' standing, constant pain, and helplessness, requiring crutches, with great insomnia, the patient after the fast ate but once a day, and in three weeks threw away her crutches and became a rosy and happy convalescent. She is still comparatively well, one year later.

But we must hasten. We delay but a moment to answer the inevitable objection that these methods exhaust the vital forces and weaken the vital constitution. They do nothing of the kind. They cure because they recuperate the only really curative power in nature—the inherent vital force. They reduce physical strength, as does sleep, by reducing vital expenditure. They invigorate the vital constitution by recuperating the vital energies. Patients gain in the reaction both flesh and strength, in many cases to a surprising degree. After 25 years of earnest investigation we are able to assert with the utmost positiveness, and sustain by indubitable proof, that vital force comes only from vital force, just as life comes from life. The reproduction theory is the only true theory. Like begets like, produces like, and cures similar. Vital force is no more transformed from the physical and chemical forces of food than its congener *contraria contrariis curantur* is the true law of cure. Food, like stimulants, tonics, labor, excitement, the yell of fire at midnight when you are in the tenth-story of a hotel, calls forth and expends vital force, and so reduces the power of cure. But, unlike the others, food yields to the organism that digests it, physical and chemical forces for the carrying forward of physical work. It enables a man to hoe potatoes, chop wood, or engage in pugilistic encounters, but it

never healed a broken bone, restored lacerated flesh, or produced even the meanest thought. Something of high degree can no more come out of something beneath it than something can come out of nothing. The power of life bears, on the contrary, an inverse relation to the power of purely physical work. If I wish to have great physical capacity without reference to the continued strength of the vital machinery I will seek to get up more steam—will seek to develop the greatest possible activity and vigor; if, on the contrary, I am seeking to repair the machinery and prolong life, I will remove the pressure of duty, let down steam, and go to bed. If I conceive that the work is of greater consequence than the man that works, I will fire up with all the fat pork, white bread and butter and molasses that I can crowd in; but if the preservation of the machinery—if its repair and long-continued usefulness is the object sought, I will bank the fires, let down steam, and give a rest. There is not, we aver, before the world to-day a more awfully destructive delusion than that which confounds vital energy with vital force, the power of physical work with the power of life, and so proceeds to force upon the afflicted invalid the conditions that even the most vigorous health would not justify—that proceeds to double the pressure upon the already cracked boiler until a dreadful explosion transfers all further labor from the physician to the undertaker, who hastily buries the remains out of sight, and lustily cries out—Next!

---

#### STATISTICS NEW AND OLD.

BY GEORGE B. PECK, A.M., M.D., PROVIDENCE, R. I.

(Read before the American Institute of Homœopathy.)

MEDICAL statistics may be arranged under two titles, general and special. The latter should contain only figures relating to particular diseases or injuries, the former can receive all others. The first are valuable chiefly on hygienic grounds, the second on therapeutic or operative, though each may be available as side-lights for purposes foreign to the original intent. Too many new-school men have kept their records even to date according to some *general* system, thereby almost absolutely



wasting their time, their paper and their strength. Hereafter let each one, especially if in charge of institutional work, specialize his reports or else discontinue them altogether.

Of general statistics but few will be noticed. By order of the Czar in 1829, Dr. Herrmann, then attending a Russian nobleman, was assigned to the charge of wards at Tul, in Podolia, for 100 days, for the purpose of demonstrating the efficiency of "new physic." One hundred and sixty patients were admitted, of whom 141 were cured, 6 died, and 18, suffering from incurable organic defects that had been treated in other hospitals, remained on hand. The death-rate was 3.64 per cent. The result was so satisfactory that in the following winter, 1829-30, by the same authority, Dr. Herrmann treated at an Infantry Hospital at St. Petersburg 409 persons, of whom 370 were cured, 7 relieved, 4 not cured, and 16 died, while 12 were under treatment at the expiration of his service. This time his mortality was a trifle higher, 3.92 per cent., yet it must have been far lower than in kindred institutions; for in 1837, at a very orthodox hospital in the same city, styled by one author the Mary's and by another the Marine, where 3356 persons were treated, 773 or 23.03 per cent. died, while 322 remained in the wards and only 2261 recovered. No additional experiments were made, however, for reasons identical with those that have thwarted so many political reforms in that alleged autocracy.

At the Hospital St. Marguerite of Paris, during the years 1849-50-51, one-half the beds (100) were under the care of Dr. Tessier, the other half (99 beds) were in charge of the regular practitioners. The former received 4663 cases and lost 399 or 8.5 per cent.; the latter received 3724 cases and lost 411 or 11.3 per cent. That Dr. Tessier should treat 939 or 25.2 per cent. more cases than his rivals in the same length of time with but a single additional bed proves he needed for the establishment of convalescence less than three-quarters the time required by his allopathic colleagues. Furthermore the cost of the drugs used by the latter was 23,522 francs, by the former between 200 and 300 francs, or about a hundredth part. Rather an important item in economics. The Administration des Hôpitaux published these figures and added: "We would encourage him to persevere in his efforts which can only benefit

humanity." As the Administration assigns patients only as beds become vacant, selection on the part of the attending physicians was precluded.

Very like the testimony of this board was that of the Board at Thoissey, Department of Aisne, where Dr. Gastier had charge of the hospital of that place from 1832 to 1848. An allopathic physician at Mâson on one occasion stated in a political paper of that city that the administration of this hospital had forbidden the doctor to practice homœopathy within its walls. Thereupon, over their own signatures, the Board declared that "since the accession of Dr. Gastier the number of deaths in proportion to the number of cases has been much less than ever before; that the cost of medicine has been almost *nil*, and that the service has been sensibly relieved by simplicity and regularity."

At the Homœopathic Hospital of the Sisters of Mercy in Vienna there were from 1833 to 1841, admitted, 5161 persons, of whom 4710 were cured, 89 were discharged not cured, 61 were remaining in the wards at the close of the period, 34 were brought in moribund and 267 others died. The total death-rate was 5.83 per cent., but if the moribund be excluded from the calculation it was but 5.21 per cent. At the General Hospital of the same city in 1838 there were 20,545 patients, of whom 2678 died or 13.03 per cent., and in 1841 there were 24,258, with 3068 deaths or 12.65 per cent.

In reference to the matter of general expense, it is instructive to note that while in 1840 the Administration of General Charities in Berlin set down the daily cost of one patient as 22½ cents (7½ groschen) the cost of the daily support of patients in the homœopathic stationary clinic was 11 cents (3½ groschen); also that in 1848, in Vienna, a patient cost 17½ kreuzers more a day in the allopathic than in the homœopathic hospitals.

It chances certain disorders to which the human race is prone are so virulent that all civilized governments take most careful cognizance even of their apprehended presence. Not a single case can escape the scrutiny of the public health officials. Fraudulent returns concerning such diseases are simply impossible. But it is in direct contest with these dread infections and under such conditions that homœopathy has achieved its most signal triumphs. Most terrific of all is yellow fever.

Dr. La Roche in his exhaustive treatise (allopathic) on this disorder which occupies two volumes of 1400 pages each, and is deservedly recognized authority on the subject, states the average death-rate is 100 out of every 350 attacked, 2 out of every 7, or 28.57 per cent. But in the epidemic of 1853-4-5 at New Orleans, Drs. F. A. W. Davis and W. H. Holcombe treated 1016 cases with but 55 deaths, 19 out of every 350, two out of every 37, or 5.41 per cent.; and in the same city during the epidemic of 1878, of 1945 cases treated homœopathically but 110 were lost, 20 out of every 350, 2 out of every 35, or 5.66 per cent., while outside New Orleans in the same epidemic 1969 cases were treated with 151 deaths, 26 out of 350, 2 out of every 26, or 7.67 per cent. On the same ground and during the same epidemic the most favorable allopathic mortality was 17 per cent., while in many places it was very much higher. Furthermore, at Portsmouth and Norfolk, Va., in 1845, Dr. Lisle Augustus Bilisoly treated 137 cases with a loss of 8, 20 out of 350, 2 out of every 35, or 5.84 per cent. But 5 of these 8 had previously been under allopathic treatment, occasioning at the mildest estimate loss of much valuable time.

Scarcely less feared by the common people is Asiatic cholera. Immediately after the epidemic of 1830-31 the president of the Imperial Council of Russia reported that in the governments of Saratow, Tambow and Twer 1273 persons had been treated homœopathically for this disease, of whom 108 or 8.48 per cent. died. At the Cholera Hospital, St. Petersburg, 636 were *regularly* treated by Dr. Lichtenstadt with a loss of 317 or 49.69 per cent. But lest it be objected that the virulence of the infection varies with the location it may be added that at Wisney, Wototschok, Russia, of 199 regularly treated for this disorder 139 or 69.80 per cent. died, while of 109 treated at the same time and place by Dr. Seider, homœopathically, but 23 or 21.10 per cent. were lost.

In 1831 Dr. Quin visited Tischnowitz, Moravia, where more than one-tenth of the entire population was attacked by cholera. Of these, 331 were treated allopathically, with 140 deaths, 42.29 per cent.; 71 by camphor only, with 11 deaths, 15.49 per cent., and 278 homœopathically, with 27 deaths, 9.71 per cent. These facts were collated by the authorities and attested by the chief magistrate.



In April, 1832, Dr. Rath was ordered by the King of Bavaria to collect authentic information as to the results of the homœopathic treatment of this disorder. He reported that out of 1269 cases treated by 14 homœopathic physicians in Vienna, Prague, Hungary and Moravia there were only 85 deaths, a mortality of 6.69 per cent., while the allopathic death-rate in the same places was above 31 per cent.

Sir Wm. Wilde, an eminent English ophthalmologist, in a work entitled *Austria and Its Institutions*, states that during the epidemic of 1836 the Leopoldstadt Hospital under the care of Dr. Fleischmann, was ordered to be fitted up for cholera patients. A comparison of results at the close of the season showed that while two-thirds of his patients recovered, in other hospitals two-thirds died. This secured the repeal of a previous edict, more honored in the breach than in the observance, however, prohibiting the practice of homœopathy in the empire.

In 1846, at the Homœopathic Cholera Hospital at Munich, 242 persons were treated, of whom 223 recovered, 13 were relieved and 6 died (2.48 per cent.).

In 1848 the 6 physicians of the Edinburgh Homœopathic Dispensary attended 236 patients at their own homes, of whom 57 died, 24.15 per cent.; while in the same city and during the same epidemic 640 cases were treated by allopathic physicians, of whom 435 or 67.97 per cent. perished.

In 1849 Drs. Pulte and Ehrmann, between May 1 and August 1, treated at Cincinnati, Ohio, 1116 cases, with a loss of but 35 patients (3.14 per cent.). So great was the contrast of their results with those of their allopathic neighbors that their veracity was publicly questioned. The doctors promptly submitted their lists, and visitation at the indicated residences substantiated the fact.

In Liverpool in 1849 of 179 persons treated homœopathically, 45 died or 25.14 per cent., while the general mortality was 46 per cent.

The General Returns to Parliament admitted a mortality in London in 1854 of 59.2 per cent. from cholera, while the returns of the Homœopathic Hospital, certified to as correct by Dr. MacLoughlin, Medical Inspector of the General Board of Health, indicated a loss of but 16.4 per cent. The same year

in Naples Dr. Rubini attended 377 cases without a single death. Two hundred of these were in a single institution. Other homœopathists attended 215 additional cases with equal success. Similar results attended the labors of Dr. Alexander Thompson Bull at London, Ontario, Canada, with 53 cases, the first of which was in the family of his Honor the Mayor, Marcus Holmes. This also occurred in 1854.

In 1884, by the attaches of the Homœopathic Dispensary at Naples, Italy, 83 cases were treated with camphor alone, with 3 deaths or 3.61 per cent., while the average mortality in that country as well as in France and Spain was over 70 per cent. Even in the United States the mortality during the last epidemic, 1873, was, according to the Government's statistics, 52 per cent., which is more than double the least successful homœopathic treatment on record.

Diphtheria ranks third as a terrorizing disease. While all persons are obnoxious to its attacks children are especially prone to its visitations. During the past 23 years 102 cases have occurred at the Tobey Street Home of Providence, R. I., 3 of which (2.94 per cent.) proved fatal. The diagnosis in each of the 36 cases in the last epidemic was verified by the culture test; that in the preceding one of 40 cases was confirmed by a special inspection by the city Superintendent of Health, Dr. C. V. Chapin. Strickler states that the homœopaths of 16 cities reported in 1890-92 a loss of 347 diphtheria patients out of 1141 or 30.41 per cent., while the allopaths lost 2996 out of 8765 or 34.07 per cent.; also that in 1893 the former lost in 11 cities 110 cases out of 376 or 29.26 per cent., while the latter lost 965 out of 2917 or 33.09 per cent. The most potent cause of this great discrepancy between the institutional and the general death-rate is that very many physicians *will not* subject their patrons to the annoyance of semi-quarantine unless the possibility of serious consequences is clearly manifest.

Dreaded almost as much as the preceding disorder is scarlatina. The Protestant Half Orphan Asylum of New York City reports that between 1842 and 1852 it had 58 cases, 5 of which were lost through ensuing dropsy and that 70 have been treated since 1874 by Dr. Woodward, who saved all but 1. Its total is therefore 128 cases and 6 deaths, 4.69 per cent.

The Tobey Street Home reports 114 cases with 6 deaths also, 5.26 per cent. According to Strickler in 17 cities in 1890-92 the homœopaths lost 157 out of 3039 cases or 5.16 per cent., and the regulars 1466 out of 17,340 or 8.45 per cent., while in 1893 in 10 cities the former lost 30 out of 693 cases, 4.33 per cent., and the latter 343 out of 4056 cases, 8.46 per cent. Moreover, eminent allopathic authorities report the following death-rates: Of persons under 12, Fleischmann 30.72 per cent. and Krauss 18.23 per cent.; under 15, Resigger 16.06 per cent.; under 16, Voit 12.50 per cent. Also in the Manchester (England) Children's Hospital the mortality for 10 years, 1877-87, was 11.8 per cent., while Collie states that in 10,000 cases of all ages the death-rate was 12.5, while between 3 and 4 it was 25 per cent.

Brief reference will be made to a few other disorders. Of measles the New York Asylum reports 342 cases with 3 deaths (2 from pneumonia and 1 from acute laryngeal phthisis), a rate of 0.87, while the Home had 129 cases with no pronounced evil result. Combining we have 471 cases with a loss of 3, 0.64 per cent., precisely the homœopathic death-rate given by Strickler for 8 cities in 1890-92, where only 7 were lost out of 1098, while the allopaths lost 297 out of 8594 or 3.43 per cent. Climatic conditions were unfavorable in 1893, for in 9 cities the former lost 14 out of 388 cases, 3.67 per cent., while the latter lost 302 out of 4385 or 6.89 per cent.

Variola visited forty-six persons at the New York Asylum in the decade, 1842-52, but removed none. It had called around previously in 1837, when it was under allopathic control, and removed 2 of the 15 children it tarried with, 13.33 per cent. There have been 85 cases of pneumonia at the asylum with 2 deaths, a loss of 2.35 per cent. Baginsky observed 60 cases, one-half in children under two years, 4 of which, 6.67 per cent., were fatal and 9 were not followed. The asylum also reports 181 cases of whooping-cough without loss, while the allopathic death-rate is said to be from 3 per cent. to 15 per cent.

No class of human beings appeals more strongly to the consideration of the true physician than pregnant women. In the welfare of one the lives of at least two immortal beings are involved. To what extent has homœopathy proved a blessing to their disorders? In the absence of other pertinent data let the



following experience of members of the American Institute prove sufficient answer.

With Charpentier the Institute has found that the influence of hysteria and epilepsy on pregnancy is practically *nil*, but while he states chorea produces from 33 per cent. to 58 per cent. of miscarriages and premature births, and slays from 29 per cent. to 35 per cent. of the mothers, our practitioners have met with no loss. More recently Barnes has reported the allopathic maternal loss as 29 per cent., and an infantile loss of not less than 44 per cent.

Cardiac difficulties have occasioned us but an infantile mortality of 25 per cent. Porak gives the *maternal* mortality at 38 per cent., of whom one-sixth were undelivered. He states that less than 58.2 per cent. went to term.

Measles are conceded to be innocuous to gravid women, but while we lose one-quarter of the offspring, Bourgeois and Levret state that abortion and premature births occur almost always, while Klotz places the figures at 82 per cent.

Scarlatina, Charpentier affirms, "terminates in abortion in the case of every woman, in death in the majority." Olshausen states the mortality in cases that came to his knowledge prior to 1876 to be 48 per cent. Braxton Hicks reports 37 cases with 27 deaths, or 73 per cent., Myers 18 with 1 death, 5.55 per cent., Boxall 16 with no death, and Legendre 23 without loss. The average total mortality is 40.35 per cent. Our own loss is 9 per cent. of the mothers and 18 per cent. of the offspring. When it occurred in the puerperal state our loss was 62 per cent., Olshausen's 75 per cent.

Mayer reports two series of cases of variola in the *enciente* in one of which 17.2 per cent. of the mothers died, 31 per cent. aborting, and in the other 38.2 per cent. died, while 46.8 per cent. aborted. Our maternal loss is 15.39 per cent., our fetal 46.15 per cent.

Respectable homœopathists do not lose more than 12 per cent. of their pregnant typhoid patients, and only 24 per cent. of their offspring. Charpentier reports 52.8 per cent. of miscarriages, and 4 per cent. of premature births, or reckoning the slight chances of survival in the latter class, a total mortality of at least 55 per cent., and more probably 56 per cent. He naively adds, "the prognosis as regards the mother is more favorable." It is to be hoped so!

Malaria has not been provocative of serious consequences to the *enciente* when treated homœopathically. Charpentier states pregnancy is interrupted in 41.3 per cent. of such women when suffering from this disorder.

Pneumonia occasions death in 14.28 per cent. of those attacked in the class of women under consideration, and an equal loss of offspring, although there are not by any means always two deaths in a single case. Ricau's figures are 27.90 per cent. and 48.84 per cent. respectively, Chatelain's 51.28 per cent. and 48.72 per cent., and Matton 26.32 per cent. and 47.37 per cent., or a general rate of 35 per cent. and 48.33 per cent.

Of consumptives who become pregnant we lose 25 per cent. within a year, and 13 per cent. of the children die within a corresponding period, but 50 per cent. will attain middle life. In Europe the maternal loss is 64 per cent., while 23 per cent. of the children died of tuberculosis alone before their seventh year, and only 37.50 per cent. maintained good health.

In puerperal eclampsia Hecker says the mortality is 27 per cent., Dohrn 29 per cent., Hugenberger 35.1 per cent., Löhlein 37.7 per cent., and Depaul 37.88 per cent. We have lost 22½ per cent.

NOTE.—During an epidemic of typhoid fever at Stamford, Connecticut, in the spring of 1895, allopathic physicians treated 284 cases with 22 deaths, a mortality of 7.74 per cent., while homœopathic physicians treated 122 cases with only 5 deaths, a mortality of 4.09 per cent. In New Haven in the same State during the years 1891–5, allopaths treated 458 cases of the same disease and supplied 119 graves with occupants, a loss of 25.98 per cent; the homœopaths treated 60 cases and filled but 12 graves, losing but 20 per cent.

Of diphtheria and membranous croup the former cared for 753 cases with 267 deaths, 35.45 per cent., the latter 146 cases with 31 deaths, 21.23 per cent.

*Regular practitioners* looked after 1271 cases of scarlatina, but lost 127, or 9.99 per cent., while homœopathic doctors watched over 209 and lost 7, or 4.30 per cent. Measles was given as the cause of death in 51 cases out of 286 allopathically treated, 17.83 per cent., and in 2 only of 106 homœopathically treated, 1.88 per cent.

## THE DIATHETIC DISEASES AND THEIR INFLUENCE UPON THE COURSE AND TREATMENT OF THE ACUTE ILLNESSES OF CHILDHOOD.

BY C. SIGMUND RAUE, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Penna, Pittsburg, Sept., 1898.)

For an acute illness to run a classical, uncomplicated course, its occurrence in a perfectly normal constitution, devoid of all diathetic taint and temperamental abnormality, is the essential requirement. Repeated careful clinical observation verifies this proposition. The influence of the structural peculiarities designated as diathesis upon the course of illnesses affecting individuals thus stigmatized is so marked that their recognition and interpretation will enable us to not only foretell the type which the disease will assume, but also give the key to treatment and decide the ultimate prognosis.

In order to fully appreciate the importance of this subject and clearly understand the rationale of the above assertions and of what will be said further on regarding treatment and prognosis, a brief *résumé* of these diseases, together with their pathology and clinical characteristics, will be undertaken as prefatory remarks.

Syphilis, rickets, tuberculosis and rheumatism are the four constitutional disorders having a practical bearing upon the diseases of childhood, both from the frequency of their occurrence and the true diathetic condition presented by each. Syphilis and rickets are closely associated clinically, although the relationship between the two diseases is by no means a necessary one. Both occur early in infancy, but the symptoms of syphilis appear in the earliest months of life, while rickets seldom develop before the sixth month.

Tuberculosis and serofula are nowadays described as synonymous terms; in fact, the typical tubercular diathesis is exemplified in the old erethetic serofulous type, but the phlegmatic serofulous type is quite distinct from this, as will be seen later on. Tuberculosis does not usually manifest itself as early as syphilis and rickets; in exceptional cases, however, it may



appear at a most tender age. Scrofulous conditions seldom develop before the second year of life, and here we have a similarity with the rheumatic diathesis, which seldom shows its tendencies before this time.

Syphilis manifests itself by characteristic lesions of the mucous membrane and skin. Besides this there is anæmia and a diffuse interstitial hyperplasia of the connective tissue of internal organs. These pathological conditions exert a potent influence upon the child's nutrition through the destructive changes induced in the liver, lungs and digestive glandular system, giving the patient a characteristic appearance. The child is under-developed, the skin is shrivelled and yellowish, and the face wears an anxious, old expression.

The first signs to appear are usually the affections of the mucous membrane—acid coryza; snuffles; hoarse, plaintive cry; mucous patches in the mouth, and gastro-enteric catarrh, inducing foul-smelling diarrhœa. In mild cases the cutaneous lesions are a simple erythema or round and oval macules on the buttocks and lower portion of the abdomen; in the more severe types pustules and blebs are likely to occur.

Besides this, condylomata around the margin of the anus, ulcerating papules on the genitals and pustular lesions on the buttocks and head, forming thick, greenish crusts which leave an ulcerated surface on being removed, are commonly found.

Osteochondritis is a pathognomonic symptom, but the condition is not invariably found.

Among the later manifestations of congenital syphilis (*syphilis congenita tarda*) are the affections of the bones, teeth and organs of special sense. Thus the periostitis and necrosis of the bones of the nose, resulting in the flattened bridge of the same; the prominent forehead, with a central depression; the irregular teeth, with notched upper central incisors—Hutchinson's teeth; interstitial keratitis and deafness.

Rickets seldom shows itself before the sixth month, and in its early stage it is only recognizable by a careful scrutiny of the case. As a rule, this disease does not attract attention until marked bone lesions and deformities have developed—a period at which, unfortunately, our best opportunities for treatment have slipped by.

This diathesis presents an anæmic, flabby, unresisting consti-

tution, in which perverted nutrition is the prominent feature. The osseous system bears the brunt of the disturbances. The process of cartilaginous and subperiosteal cell-growth is excessive, while the deposit of lime-salts for the completion of the process of ossification is below normal. Besides this, there is excessive destruction of bone already formed, through an abnormally active formation of medullary canals and canaliculi.

The child's appearance is characteristic when the osseous changes are well advanced. The head is large and square, the chest small and laterally depressed, with prominent sternum—the so-called chicken-breast. More commonly the peri-pneumonic groove of Trousseau and beading of the ribs. The epiphyses are enlarged, notably in the wrists; the abdomen is large and distended.

The muscular system and ligaments are lax; the spleen is enlarged, and anæmia is a prominent symptom, leucocytosis being present with the splenic enlargement. Local sweating, especially about the head, is another prominent symptom. Disturbances in the nervous system show themselves as heightened reflex irritability, with insufficient inhibitory control.

A type again distinct from the foregoing is the tubercular diathesis. These little patients, doomed to succumb to the ravages of tuberculosis, are perhaps the most pitiable objects encountered by the pædiatrist. We recognize them by their delicate, "airy, fairy" appearance; frail constitution; small, slender bones; slight muscular development; their transparent skin, through which large blue veins are prominently shown; soft, silken hair; long eyelashes; bright, languid eyes; oval face. They are of a passionate and lovable disposition; the mind is active and precocious, and restraint, rather than coaching, is necessary to keep the delicate nervous organization in equilibrium.

These are the cases in which general tuberculosis finds such a favorable soil and strong foothold, the slightest provocation in the form of some acute illness sowing the seed for the commencement of the trouble.

The scrofulous diathesis, which likewise invites tubercular processes, of a different character, however, shows itself quite apart from the above. The phlegmatic type of scrofula, which is the true scrofulous diathesis, is characterized by large frame;

large coarse features; thick lips and nose; coarse, doughy skin with abundant subcutaneous fat; large, distended abdomen; enlarged lymphatic glands in the cervical and other regions; eczematous eruptions. The muscular system is feeble, the pulse soft and weak, and the temperature often subnormal from deficient oxidation of tissue.

In these children tuberculosis becomes a local affection, chronic in its course, and attacking chiefly the lymphatic glandular system and the joints, which present a peculiar vulnerability of tissue.

The purely tubercular and scrofulous types are quite distinct, but it is not invariably found so in practice, and frequently cases can only be classified from a preponderance of conditions favoring the one or the other. Again, I have repeatedly seen the transition from one type to another. This is an observation of definite significance to the pathologist and therapist.

Of the rheumatic diathesis little more can be said than that it is an hereditary predisposition to certain forms of arthritism and abarticular rheumatic phenomena, a series of affections characterized by a retardation in the process of nutrition. It invites conditions which are acute and have a tendency to appear in recurring attacks, and eventually exert an important influence upon the circulatory and nervous system.

Acute articular rheumatism is rare during childhood, but in its place we will find acute recurring tonsillitis and pharyngitis; bronchitis; erythema, urticaria and purpura; endocarditis and pericarditis; subcutaneous fibrous nodules and chorea to indicate this dyscrasia.

Let us now consider the practical bearing of the recognition of these types of morbid constitutional peculiarities. Rachitic children, it is well known, are very prone to develop catarrhal affections. The same show a marked tendency to run a tedious course, as a result of structural changes and ulceration of the mucous membrane.

Again, owing to the peculiar condition of the nervous system, trifling ailments are likely to be ushered in with convulsions, and in fact convulsions after the first year should always lead us to suspect rickets. During an illness they emaciate rapidly and convalescence is much protracted; frequently children who were beginning to walk nicely require weeks to regain this



function. By a recognition of the true reason for this delayed convalescence or sustaining cause for a disturbance, in other words, by direction of our attention to the rickets, treatment will be carried out on the most successful lines.

Pneumonia is likely to run a most rapid and alarming course, death frequently occurring within forty-eight hours of the initial rise of temperature; the patient succumbs to hyperpyrexia. The anæmia and leucocytosis may account for this, as there is very rapid infiltration and marked pulmonary oedema associated with the process. The mechanical impediment offered by the soft condition of the ribs to a full expansion of the lungs under interference of any kind with the normal respiratory function must also be borne in mind in any disease of this tract.

Syphilitic children show a poor chance against most acute illnesses, as one would naturally infer from a knowledge of the grave character of its pathological processes, and they most frequently succumb to intestinal and pulmonary disturbances. Nevertheless, syphilis *per se* is likely to yield kindly to treatment, and therefore much can often be done for these patients by constitutional treatment. The best results are obtained by symptomatic prescribing, remembering that although mercury and its compounds is the most frequently called for remedy, nitric acid, kali bichr., kali jod., aurum, kreosotum and thuja are all indispensable.

In acute pulmonary and most acute infectious fevers the presence of the tubercular diathesis offers a most unfavorable omen for the recovery of our little patients. Tubercular broncho-pneumonia, tubercular meningitis and acute general tuberculosis all follow in the wake of the acute infectious fevers, especially measles, whooping-cough, typhoid fever and influenza. An ordinary broncho-pneumonia will become tedious; the temperature remits, leading us to suspect a malarial condition or even typhoid fever; but the case continues, in spite of our best directed efforts, towards a fatal termination. Our sheet-anchor here is arsenicum, arsen. jod., calc. c., silicea and sulphur. In the absence of strong indications for another remedy I employ iodoform, 3x to 12x trituration, with the greatest confidence, and it has certainly yielded most gratifying results in desperate cases under my care.

Among the dangers to the scrofulous child are ophthalmia and otitis. In the former permanent injury to the cornea may be anticipated, while in the latter life is immediately at stake, for tendency to caries of the temporal bone carries with it the possibility of a future cerebral abscess.

Skin eruptions in the strumous run a prolonged, stubborn course; so with catarrhal affections which are characterized by irritating, offensive discharges, inducing eczema and lymphadenitis in adjacent parts. The scrofulous diathesis predisposes to croup, hydrocephalus and tuberculosis, and it is claimed that the majority of children dying of these affections are scrofulous. The remedies suggested are numerous and suit as well to the acute conditions as the chronic underlying dyscrasia.

The influence of the rheumatic diathesis is perhaps most strongly exhibited in affections of the serous membranes. When the thoracic viscera are involved the results of such a predisposition are most grave, and we frequently see both pericarditis and endocarditis and pleurisy in the same subject, making recovery very doubtful.

A simple sore throat assumes the type of rheumatic angina; permanent deformities, such as wryneck and stiff joints, are likely to follow upon a simple inflammatory process. The rheumatic remedies are particularly applicable to all of these conditions, notably bryonia, cimicifuga, guaiacum, phytolacca and rhus.

The symptomatology of many of our remedies is so suggestive of types of constitution that they are readily recognized clinically. Thus, the calc. phos. baby is too well known to require description here, and the value of this knowledge is inestimable in the sick-room, no matter what the condition may be, whether acute or chronic, pulmonary or intestinal, etc.

Strike at the foundation—this is the lesson taught by these examples. All acute conditions can but assume the type of the soil upon which they grow, and their course and treatment follow accordingly.

---

CINNABAR IN BALANO-POSTHITIS.—Dr. Pinart, of Barcelona, relates a case of this affection, not complicated with chancre, where cinnabar 6x, two globules every two hours, brought about a cure in fifteen days.—*Revista Medica de Barcelona*, No. 3, 1898.

## A COMPARISON OF RHODODENDRON AND RHUS TOX.

BY WILLIAM D. YOUNG, M.D., BUFFALO, N. Y.

PERHAPS no two remedies given for rheumatism have a closer similarity in their symptomatology than rhododendron and rhus tox. Bryonia and rhus are very similar, but have a few marked differences. Rhododendron and rhus have no such convenient handles, therefore a glance at their relations may be of value.

Both remedies have rheumatic pains, especially in the aponeuroses. Rhododendron perhaps affects the periosteum more than rhus. Rhododendron affects small joints most frequently, and is more often indicated in the chronic form of inflammation; rhus affects both large and small joints, and is frequently indicated in acute or chronic forms of inflammations.

The pains of either are not especially characteristic as to quality, being largely tearing, boring, digging, drawing or tensive throbbing in both. In both there is stiffness on motion, but rhus has this to a much greater extent. Rhus has more bruised, sore or spinal sensations than rhododendron, especially in the softer tissues. Rhododendron has much soreness of the periosteum, as felt over the condyles or other projections. Rhododendron presents some paralytic, tingling, "asleep sensation," and weakness, but rhus has this to a marked degree. Paralysis is prominent under rhus.

There is from rhus a weakness, lassitude and trembling in the limbs due to this paralytic condition, with numbness, pricking and heaviness not found in anything like so characteristic a form under rhododendron. Rhododendron has relief of the pains from motion; one has to keep moving all the time or the pains return in greater severity. The stiffness is also relieved by moving about.

Rhus also has relief from motion—as much as, or more so than, rhododendron; but we find a similarity with a difference here. The difference is the paralytic condition which is present under rhus. The rhus patient is stiff, and has much pain when he



has been quiet for a time (just like rhododendron), and he has to get up and move about. This at first gives him pain, but passes off when he has gotten a little limbered up. Thus far we find the similarity; now the difference comes in. The rhododendron patient continues to move and thereby finds relief, while the rhus patient does likewise for a time, until the paralytic condition present makes him feel weak, tired, and causing the pains to be renewed from weariness, so that he has to seek rest once more, to finally go through the same round again. This restlessness occurs in bed likewise; he tosses about until weariness forces him to rest, but in a short time he has to renew his tossing. This accounts for the symptom, "motion relieves, but continued motion aggravates."

Rhododendron has pains as above stated; these are greatly affected by a change of weather from warm to cold windy weather, and especially if this be due to electrical storms. He feels these changes in the air more before the storm comes than while it is present or after it has passed. But these storms bring high winds, as a rule, and the rhododendron patient is very sensitive to these cool winds; he is even affected when he is in a warm room or bed. This character of atmospheric change is common only in the summer months, for electrical storms are rare in winter; so rhododendron is especially applicable to rheumatic patients who are troubled during the hot weather.

The rhus patient is also affected by changes in the weather, but it is not the change itself so much as the cold weather. Rhus has marked aggravation from cold. The patient is much worse when the storm is raging or has just passed (the cold air comes with and after the storm), thus differing from rhododendron. Rhus patients have their rheumatism set up or renewed by getting wet when they are perspiring, and there the element of cold comes in again. The aggravation from cold or cold air must be kept in mind to appreciate the difference in these two closely related drugs.

So rhus is more often of service in winter or the colder months, when cold is the condition always present to exert its aggravation.

The rhododendron pains have a habit of intermitting for days at a time, seemingly spontaneously, when the patient is

pretty free from trouble; then they recur again. This intermission may be explained that in the summer, when rhododendron is most often useful, the fine days between storms allow of a cessation of trouble; the recurrence is due to the atmospheric change preceding a storm.

Rhus does not present this to such a degree, for as it is most useful in colder weather, there is not the intermission of fair warm days to quiet the existing disease. Rhus pains are better from dry warmth and from pressure.

Rhododendron does not present these characteristics especially. Rhododendron has aggravation of its pains at night, and especially after midnight.

Rhus has aggravation at night also, but more characteristically early in the morning from 6 to 8 (that is, when they are first beginning to move about for the day and before the stiffness of the night's rest has worn off), and along through the afternoon and evening from 2 to 8 P.M. (or, as we may see, when they are getting tired from the morning's work).

Rhododendron affects the right side of the body more than the left in the ratio of about 9 to 7.

Rhus affects the left side more than the right in the ratio of about 7 to 4.

It is with difficulty that we draw a marked differentiation between two remedies so similar in their action, and especially where one has a short proving only. Little is known about the direction of the pains of either, or which side is first affected and which afterward. Farrington says the pains of rhus go from right to left. There are more left-sided symptoms in the provings than right-sided however, though that need not necessarily contradict the statement.

Lilienthal gives the pains of rhododendron as moving from above downwards, even to the fingers and toes. Cases cured, or provings made, should have the order of sides and direction recorded.

---

GONORRHEA.—Schultz has used argentamin with good success as follows: 10 per cent. solution for uterine gonorrhœa, 2 per cent. for urethral gonorrhœa and 5 per cent. for rectal gonorrhœa. The gonococci disappeared in a shorter time than after the nitrate of silver and with less local irritation.—*Centralblatt für Gynäkologie*, No. 36, 1898.

## LET US REASON TOGETHER.

BY CHAS. H. HUBBARD, M.D., CHESTER, PA.

(Read before the Homœopathic Medical Society of Delaware County, Pa.)

ASSUMING that the physician is well qualified by nature and by education for the practice of medicine, that he continues to be a student, alert, progressive, and a sincere believer in the principles of homœopathy, are there any other requirements necessary to insure the success of a remedy prescribed according to the law of *Similia Similibus Curentur*? And are we always justified in expecting favorable results from our remedies? The humiliating fact "will not down," that no matter how capable the physician, no matter how accurately the case is diagnosed, the symptoms collated and the remedy selected, lamentable and exasperating defeat is of frequent occurrence. While we recognize that man is a finite being, subject to the immutable laws and limitations of his existence, still he cannot hide behind a cowardly subterfuge and charge his failure to a "dispensation of Providence." No, many times the practitioner himself is the culprit.

It is possible that the ingenious and indefatigable germ-hunter may eventually find a bug with a skull and cross-bones branded on its *gluteus maximus*, a species of malignant micro-organism that evades all efforts to disenchant or exterminate, and dooms its unfortunate possessor to a life of hopeless misery. However, until the presence of such an imp of backward progressiveness is established, we are warranted in accepting the postulate that most of the disorders afflicting the human family are curable, or at least amenable to treatment.

It is impossible for the essayist, even though he possessed the necessary ability, to go through the whole broad domain of medicine and surgery, and present facts culled from the great field of medical lore to demonstrate the lines of success or failure that often lie within the grasp of the physician; but he will attempt to refresh the minds of his auditors, and perhaps excite their interest in a line of profitable thought and investi-



gation. He will refer to a few conditions, the recognition and proper treatment of which will often pave the way to a successful homœopathic prescription.

Remedies, like men, have their limitations, and we must not expect them to achieve the impossible. They work well when the way is clear and common sense directs their efforts. A bigot or an ignoramus may relegate the most reliable polychrest to a state of hysterical ineffectiveness. As every special sense of our organization has its own special function and field of operation, however much it may influence or be influenced by other forces of the human body, so every drug that enters into our *materia medica* has its own specific work that cannot be usurped by another.

Prof. Dudley, in an article entitled "Homœopathy: Its Origin, Meaning and Scope," says: "The whole view of molecular science as held nowadays favors the theory that homœopathic action is started only upon a disordered vital function." And it therefore "follows that the curable conditions which the homœopathic remedy is capable of affecting are those which depend for their causation or continuance upon disorder of vital activities, and that disorders otherwise maintained must be treated otherwise."

In accepting this rational hypothesis we must logically conclude that disturbances of the human economy are not all disorders of vital function, but may be physical, mechanical, chemical or psychological. There may exist a combination of one or more of these causes requiring a combined method of treatment. And it is when we ignore these vital facts, and attempt to force the homœopathic remedy into a field of action wholly foreign to its nature, that we bring defeat and odium upon ourselves and the cause of homœopathy. The blind following of any one method to the utter exclusion of the other is to be deprecated.

Let us consider a few conditions that shall demonstrate in a practical manner the causes that favor or prevent a successful homœopathic prescription.

It is stated that all forms of bacteria "perish in an excess of their own products." And so, likewise, man generates within his own body sufficient poison in six hours to kill him, if it were not continually eliminated. When, therefore, the natural

excreta of the body fail to be cast out through nature's channels, it is worse than idle—it is criminal—to expect satisfactory results from any treatment that does not consider such abnormality. This superfluous and uneliminated poisonous product may exist in the urine, fecal matter, perspiration, mucus secretion, etc.

But I desire to refer you to a few special conditions that come more particularly under my own observation. A patient presents himself with red, swollen, scaly eyelids; perhaps styes and tarsal cysts form. Another complains of headache, heavy, tired feeling of eyes; while still another has, apparently, ciliary or supra-orbital neuralgia. Again, others will have symptoms as though sand or sticks were in the eyes, with possible photophobia and lachrymation.

Now, all the above symptoms—and more—may exist, and the visual acuity, apparently, remain unimpaired, thereby leading the practitioner to conclude that no optical error exists. Remedies may be prescribed, and their employment frequently bring relief, but failure to win satisfactory results generally ensues. The above symptoms almost certainly demand lenses for their removal, and it is an offence to expect any remedy to take the place of a refractive body.

Again, the vision is frequently lost because the medical adviser fails to dilate the pupil with a mydriatic when suffering with iritis and other diseases of the eye, and physicians have been known to insist for years in exhibiting the indicated remedy for epiphora, blephorrhœa, marginalis and other anomalies of the lachrymal apparatus when no internal medication could possibly remove the lesion. Remedies in such cases, when accompanied by instrumental interference, are of the greatest value. Want of harmony of the ocular muscles, known as heterophoria, is a derangement not easily recognized by the general practitioner, but is often responsible for physical and mental disturbances of the most varied and distressing character. Here the homœopathic remedy will often work marked amelioration, but as refractive errors are usually associated with the muscular trouble, the properly-selected glass will often correct the muscular defect. But exercise of the muscles and possibly tenotomy are requirements frequently demanded.

The ear, the least understood and worst treated organ of the body, is made to suffer innumerable discomforts, and its unfortunate possessor often surrenders life itself on the altar of conceit and ignorance. Any physician who persists with internal treatment in long-standing cases of middle-ear disease, to the utter exclusion of other treatment, is assuming responsibilities that *he*, and not the indicated remedy, should be answerable for. And, conversely, the employment of treatment that ignores the homœopathic remedy can have no place in the armamentarium of the educated physician. Again, when abnormal accumulations are permitted to remain in the ear without intelligent and thorough removal, when a painful, bulging membrana tympani is giving the patient excruciating agony, and paracentesis is not employed, when furuncle or phlegmonous inflammation of the external auditory canal is causing the most exquisite suffering, and the medical attendant fails to make free incision, he not only needlessly prolongs the agony, but he is nursing the seeds of irremediable ear disease and inviting death itself to come in and claim its prize.

Other patients, with a confidence in their doctor deserving a better fate, are permitted to go through life as "mouth-breathers," when the affliction is due to hypertrophied turbinates, thickened and deflected *sæpta*, adenoid vegetations, enlarged tonsils, etc., when a little mechanical treatment would remove the neoplasia and give prompt relief, thus paving the way to a permanent cure by the administration of the appropriate remedy. On the other hand, the surgeon who resorts to instrumental interference, and fails to persist with the suitable internal medicament, is bound to meet, as he deserves to, his "Waterloo."

What has been said regarding the abnormal conditions of the eye, ear, nose and throat, and the procedures that invite defeat or most certainly lead to success, can be as truthfully applied to nearly every portion of man's organization. When one enters upon the study and practice of medicine he virtually enters into a solemn compact with God and man to labor unceasingly to perfect himself in all that pertains to his profession; and to meet the sacred obligations imposed by such implied contract, his efforts must not be minimized or circumscribed by an obstinate adherence to a bigoted interpretation



of any particular system of medical practice, neither should he arrogantly scorn an established law of cure and presume to rise superior to the supreme environments that govern other mortals. A proper recognition of the correlation of the various causes of morbid phenomena and a treatment in harmony therewith, would materially assist in attaining that high degree of perfection and efficiency which should be the aim of every true physician.

---

### A CASE OF CHRONIC DIFFUSE NEPHRITIS IN A CHILD.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

CHRONIC nephritis in children is by no means as rare as physicians generally believe, for if one do not accustom himself to examine the urine of his patients methodically he will be treated to some curious and unpleasant surprises. For instance, only a few weeks ago I saw a case where a boy of ten years, who was seemingly in good health beyond suffering from crops of boils, but whose urine, on examination, was found to be loaded with albumin. Another case, where a little girl suffered from profuse menstruation, was discovered, after examination, to be a sufferer from chronic interstitial nephritis; and still another, a sufferer from long-lasting headache, had a urine of low specific gravity loaded with phosphates, a few fatty casts, and much epithelium. The urine of children is well worthy of study, and careful study at that.

Many children with skin diseases, with poor digestions, and who are crammed with tonics and cod-liver-oil emulsions, and such fortifying elixirs, are found to be weak, puny, and pale-looking, not from poor digestion but from faulty elimination. Such conditions are very frequently the vestiges, the relics of slumbering fires, which remain after scarlet fever, diphtheria, more rarely malarial fever, and, in fact, the whole series of infectious and contagious affections, not excepting mumps and measles or varicella.

Above all diseases, we think of scarlet fever as the affection which is most liable to be followed by renal complications. But the other common febrile diseases of children will bear watching.

Le Gendre—*L'Albuminurie et Nephrite Chez Les Enfants, La Semaine Medicale*, 1895—emphasizes the dangers of these simple affections, and also of tonsillitis being succeeded by renal sequelæ. But the best and most advanced light is thrown on this subject by an excellent little pamphlet by Prof. O. Heubner, of Berlin, *Ueber Chronische Nephritis und Albuminurie im Kindesalter*, Berlin, 1897—where he considers all the varieties of nephritis (chronic) in children. I must say that I have found his work a very useful and instructive one, illustrated as it is with cases bearing out his assertions and conclusions.

May 20th, of this year, a little girl of twelve years was brought to my office. She was of healthy parents of German descent. On the father's side the grandfather had died at the age of some seventy with a chronic interstitial nephritis, and his wife fell dead suddenly while walking in the yard. The mother's mother was rheumatic, but in otherwise good health. The maternal grandfather died of an obstructive nephritis with a history of years of suffering from a cysto-pyelitis, from an obstructed urethra.

The little patient had been always healthy but slim, and never chubby or fleshy. Four years before she had had an attack of remittent malarial fever of not severe course, from which she seemingly recovered.

When I saw her she had been ill for seven weeks with neuralgic pains in her legs, which had gradually so grown in severity that life was a misery. These would come on paroxysmally every half-hour to two hours, when she would writhe, cry out and groan from their intensity. She was very pale, her eyes dark with black rings; she had lost a great deal in flesh, her bowels were constipated, her appetite gone, and she was weak and frail in strength. She could walk off well without pain; her joints were not swollen nor painful to pressure; she had no headache; no vomiting; her sleep was poor on account of the pain. Her lungs were normal. Her heart was rapid, and the valvular sounds accentuated, above all that of the aortic valve. Her nervous system was intact as far as I could learn from tests. Her eyes reacted normally to light. The patellar reflexes were exaggerated somewhat.

The urine was turbid, decomposed easily and quickly on standing, and was loaded with mucus. The sp. gr. was 1009.

The urine smelled ammoniacal and rank. Albumin was present in goodly quantity, for, on standing, the nitric acid test revealed a ring of contact  $\frac{1}{16}$  of an inch broad; the albumin was present in large retractile flocculi. This retractibility of albumin is said by Bouchard to be characteristic of renal diseases with lesion of the epithelia; while, if it be diffused through the urine as an opacity without formation of flocculi, the interstitial substance itself, rather than the excreting epithelia, is affected. Spiegler's test, a very delicate one, showed albumin to be still more distinctly present. Microscopically there were numerous epithelial masses; granular and hyaline casts, dark, with a few red blood-corpuscles. The quantity of urine was reduced to about a pint in twenty-four hours. The valvular sounds were accentuated, especially that of the aorta, which was decidedly snapping. Her pulse was somewhat harder in tension than normal and eighty in the minute. No headache; appetite poor and bowels constipated. Now and then a disagreeable sensation of fulness and aching in the eyeballs.

I gave her canth. tr., gtts. ij.; tr. aconite, gtts. iij.; colchicine, two diurules in twenty teaspoonfuls of water, five times a day. I gave at the same time a very unfavorable prognosis, and diagnosed chronic diffuse nephritis. The bowels were kept open, fl. ext. of cascara sagrada, 15 to 20 gtts., two or three times a day.

I kept up this treatment for several days, with the result that the sp. gr. gradually crept up somewhat, and the amount of albumin varied now and then slightly. The pains were so severe that I was forced, against my will, to administer morphine,  $\frac{1}{8}$  grain, every three, and then every two hours, at times. This state of affairs continued for about a month, with some but not with any great improvement. I was much worried on her account, as I did not wish to keep giving morphine in such doses. I finally, reasoning that the pains were possibly due to anæmia, gave her an elixir of gentian and iron in half-teaspoonful, and later in teaspoonful doses, though the canthar., colchicine and aconite were continued in the same manner as before. I had also employed any number of other drugs and measures, but unsuccessfully. From that moment she began to improve. The urine increased to 1018 sp. gr., her appetite picked up, her bowels moved, and the pains began to decrease in severity. The urine commenced to look clearer, decomposed less readily



on standing, and in general she was better. I left off all drugs except the elixir, and in two months and a half from date I find her urine clear, of a good amber color, not decomposing easily, with not a trace of albumin with the most delicate test (Spiegler's), her strength very good, for she runs about almost as well as any child, her cheeks taking on a fresh color, and her appetite is also good. Her bowels move regularly, she gradually gave up the morphine without any yearning for it, she not knowing what it was, so that to-day she is in quite a satisfactory condition.

I attribute all the success to the iron. I have found from experience, in a number of cases of nephritis with a urine of low gravity, that iron will increase the secreting power of the renal epithelium, so that the kidney is enabled to throw out of the system more waste-material, and consequently the sp. gr. of the urine rises. I had often thought on this, and it never seemed clear to me why iron should act thus until, in reading Haig's work on *Uric Acid*, I noticed that he stated that this mineral would cause a retention of uric acid in the system, in the same manner as lead. The quantity of urea also sinks. In his work—*Uric Acid*, London, 1892, p. 26—he gives a plate illustrating this point. Dr. Garrod—*Gout and Rheumatic Gout*, London, 1859, p. 453—speaking of iron preparations, says: "These preparations are very likely, when given indiscriminately to gouty subjects, to excite a paroxysm of the disease, and for the most part are contraindicated." On another page he states: "It is a well-established fact that metallic impregnation is capable of inducing pains in the extremities which bear a close resemblance to those of rheumatism." If iron will act thus, then in subjects suffering from these states it ought to act alleviatingly when prescribed according to the law of similars. Certainly in my case it acted well, and probably homœopathically. It is the only drug that I know of which will increase the excretion of waste through the kidneys and cause the sp. gr. of the pale urine to rise. Especially in diffuse and interstitial nephritis in the chronic form, when the urine is light and pale, with a fair quantity of albumin, it appears to act very satisfactorily, reducing the quantity of albumin and bringing up the sp. gr. of the urine. From Garrod's remarks it seems to be homœopathic to neuralgic pains in the legs, and in fact, I have remarked, in the pseudo-rheumatism of Bright's disease.

## EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

## HOMŒOPATHIC METHODS.

ON several occasions within the past few months we have expressed the hope that the circumstances and conditions of the war might offer opportunities for homœopathy to demonstrate its efficiency, and to prove by deeds its equality in every respect with the dominant school when applying for governmental recognition. The general condition of the medical service in the army made it impossible for the homœopaths who entered it to make their influence felt; but we are happy to learn that at least in one instance there has been an official recognition and appreciation of our work.

In acknowledging to Dr. Mohr the receipt of reports of soldiers discharged from the Hahnemann Hospital of Philadelphia, Major D. C. Peyton, Brigade Surgeon, U.S.V., writes, "I desire to express to you my appreciation of the completeness of the reports which you have furnished this office from the start of treatment of soldiers in your hospital. Your reports have been among the most complete and most satisfactory that have been received at this office."

When it is said that these reports were no gilt-edged prize-competition reports gotten up for a special purpose, but just the regular ones, such as our hospital is accustomed to compile, it will be seen that they furnish a clear indication of the conscientious care which characterizes homœopathic methods.

We say homœopathic methods because we firmly believe that the study of homœopathy, with its necessary attention to details and minutiae, is peculiarly adapted to cultivate habits of close observation and systematic methods. We should perhaps in justice call them Hahnemannian methods, for it was he who brought them into prominence and illustrated their application, but they have now become essentials in the development of homœopathy.

A careful study of the advance made in general medical science, trifling as it has been in some directions, will show, we

think, that it has been brought about by applying methods which up to the time of Hahnemann had been either entirely neglected or only sporadically adopted, and which he was the first to insist upon as essential, and which he and his followers applied as far as the circumstances of their times permitted. Not only in lessening the quantity of drugs administered and in limiting the abuse of polypharmacy has the influence of homœopathy been apparent, but principally in the whole manner of approaching the study of disease.

Were the same impartial methods which are now followed in the investigation of diseased conditions and in the building up of the science of pathology applied to the study of the phenomena of drug action in disease, we would soon see all sects and schisms eliminated from the field of medicine, and a true science of therapeutics developed, with homœopathy as its basis, in place of the crass empiricism, called treatment, of the present day.

The efficacy of homœopathic therapeutic methods is further illustrated in the report of the work of the hospital among the soldiers as given in the Philadelphia *Public Ledger* of November 15th. Two hundred and thirty soldiers were treated—133 as out-patients, 97 in the wards. Of the latter, many were severe cases of typhoid and typho-malarial fevers, and several of appendicitis and hernia requiring operation. One neglected typhoid patient, beyond hope of recovery when admitted, died. Eighty-seven have been discharged, and 15 remain, most of whom are convalescent.

Such are the deeds upon which we last month exhorted the profession to build its hopes of future public recognition.

---

#### THE PHARMACOPŒIA.

Now that the war of words aroused by the publication of the *Pharmacopœia of the American Institute of Homœopathy* has somewhat subsided, it may not be amiss to see how the matter strikes outsiders.

In a paper entitled *Homœopathic Pharmacy*, in the *Eclectic Medical Journal* for September, by Prof. J. U. Lloyd, every line of which shows a friendliness which the author also dis-



tinely avows, we find the following closing bit of advice: "Let these minor differences serve but to tax your energies to the utmost in behalf of the general cause in which all homœopathic pharmacists and physicians are engaged, and remember that internecine quarrels published to the world are likely to be pushed along by rivals."

It may be that some of us may not be willing to call the differences minor differences, and in so far as some of them seem to conflict with the generally accepted clinical results, we would not be disposed to belittle their importance. The fact that the application of our remedies is theoretically founded upon their provings of them, as prepared by Hahnemann, would seem to demand that the method of preparation should ever remain the same, so long as these provings are used as guides. But has it ever been demonstrated, or is it probable, that slight differences in "certain pharmacal details that to an outsider appear to be of less importance than they are in the eyes of the persons engaged in the discussion" would so change the results of provings, if made at the present time, as to lessen the value of the old ones? We think not. The labors of Dr. Hughes, if they have proved nothing else besides his own indefatigable industry, have at least shown that our present collection of symptoms cannot be regarded as a verbally inspired record. We can hardly suppose that slight changes in the mode of preparing the remedies would produce any greater changes in the actual effects than have resulted in our present materia medica from the transcription and arrangement of the original records of provings, as shown by Dr. Hughes.

If then, changes *per se* cannot be supposed to vitiate the value of our materia medica, the only question to be decided is whether the authority of Hahnemann is to be regarded at the present time as absolute.

As the paper referred to justly says, "It is evident that unless Dr. Hahnemann was more than human—infallible—his methods and his products should from time to time be improved upon by men who make homœopathic galenic preparations a life study, and the writer believes that the founder of homœopathy would be no less appreciative than himself of these men and their accomplishments, were he among us."

It seems but rational that, making all due allowance for

Hahnemann's superior knowledge of chemistry and pharmacy, the advances in these branches of science would render possible some advantageous changes in his methods. Whether such changes, while possible, are necessary or advisable, is of course a question to be decided by our professional pharmacists, and in deciding they should be influenced neither by a fear of rendering our materia medica worthless nor by an overweening respect for the authority of Hahnemann. Should they allow themselves to be influenced by such motives, just in so far do they weaken their cause in the eyes of the members of our own profession, and expose the cause of homœopathy to the animadversions of its enemies. Not every one will judge as leniently of the acrimonious dispute which has raged as our friend, Professor Lloyd, has done. Every sign of a want of harmony in our ranks is hailed with joy and exploited by those who desire the downfall of homœopathy, and gives fresh occasion for dire predictions of its speedy disruption. It were better that such questions as the above, about which we are confident that the majority of homœopathic physicians are practically indifferent, should be settled, so to speak, in executive session, in the committee-room, and when there settled be allowed to remain so, and the result accepted as final.

---

#### CONGENITAL CONSTIPATION.

IN a late discussion on the "Causes and Treatment of Habitual Constipation in Infancy," reported in *Pædiatrics*, Dr. A. Jacobi calls attention to one to which he was inclined to ascribe a great deal of importance, and which we know is frequently not recognized by physicians, namely, the anatomical peculiarities found in the intestine of the infant.

It is readily seen how important a factor this becomes, both in the prognosis and treatment.

The colon of the infant at birth is about three times the length of its body, while that of the adult is but twice the length of his body. This excess of length falls to the descending colon, since both the ascending and transverse are comparatively short. The sigmoid flexure is very long, and some-

times there are two and even three sigmoid flexures found in the infant, one covering the other.

In addition to this, the colon in the infant is narrow, and, as a natural consequence of these anatomical conditions, we have a retarding and a desiccation of the feces, in their slow, downward progress. It is obviously vain to hope for a cure of the resulting constipation by the usual means, dieting, etc., until the normal development of the colon has been completed; the only means of combating the difficulty is by daily enemata. These latter are, according to Dr. Jacobi, perfectly harmless if not combined with irritating substances, such as soap and glycerin.

This anatomical peculiarity usually lasts a year or two, but may last a number of years, or even remain persistent through life.

The treatment of chronic constipation is at best, even with homœopathic remedies, often a thankless task, requiring the closest observation and the most careful individualization if we would hope to cure. Hence a recognition of the above-mentioned natural predisposition to constipation in the infant may often guard against too sanguine promises on the one hand, and against too bitter disappointments on the other.

---

THE USE OF CALCAREA ARSENICA.—Majunder, of Calcutta, regrets that the arsenite of lime is not more often used by homœopathic physicians. It is remarkably efficacious in fever cases—that kind of remittent and intermittent fevers which is recorded as masked malarial fever. When there are few marked symptoms but considerable constitutional disturbance the remedy is curative. Chilliness is a marked symptom in the commencement of this sort of fever. In the “guiding symptoms” we have chilly cramps over back toward arms and chest. It originates always inwardly, with a sensation as if the skin and adjoining parts were hot. Fever generally in the afternoon, with a sensation as if the abdomen were puffed up; much thirst for cold water, afterward loss of appetite in the evening. Heat of chest, with palpitation; night sweat after 3 A.M.

These are guiding symptoms and indications in many cases of hectic fever. It may be useful in prolonged cases of fever which assume a chronic form. The writer quotes several cases in which the value of calc. ars. was demonstrated. In infantile enlargement of the liver, a disease peculiar to India, this drug has proven itself invaluable.—*N. A. Journal of Hom.*, Sept., 1898.



## GLEANINGS.

REICHMANN'S DISEASE.—Continued hypersecretion of hydrochloric acid, as first described by Reichmann, is, according to Roux (*Gaz. d. Hôp.*, Paris, 1897, No. 61), almost always due to some pyloric or subpyloric organic stenosis, more or less complete, leading to irritability of the gastric mucous membrane, and consequent hyperacidity. The disease may be temporary or permanent in character, and range from merely simple to absolutely continuous excretion of hyperacid juice. Stasis of the gastric contents is an important factor in its causation; removal of this condition the most important indication for medicinal or surgical treatment.

Gintl (*München. Med. Wochenschr.*, 1897, No. 23), corroborates the preceding.

The presence of acid contents in the fasting stomach follows increased irritability of the mucous membrane. Chronic continuous secretion denotes some disturbance between the stimulating cause and the effect. Cases certainly do occur in which continuous secretion is a primary condition, not a secondary symptom only.

Carli and Fantino ("Les sténosis pyloriques," etc., referred to in *Arch. f. Verdauungskrankh.*, Berlin, 1898, Bd. iv., Heft 1), found in forty-one patients operated on for non-malignant stenosis of the pylorus (in nine contracture of the orifice was found, in the rest stenosis was thought to be due to spasm), a greater or less degree of hyperacidity. They are inclined to regard the spasmodic contraction of the pylorus as primary, irritation from the retained contents calling forth a secretion of hyperacid juice. They do not think that Reichmann's symptom-complex is ever developed except after the occurrence of pyloric stenosis.

Carli and Fantino (*Semaine Med.*, Paris, July, 1897), concluded, from the results obtained by them in forty-one cases of pyloric obstruction of benign origin, that Reichmann's disease is not an entity, but that it depends upon contracture of the pyloric orifice, often a functional spasm, caused by irritation followed by hyperacidity. Retention of food in the stomach may arise from obstruction at the pyloric orifice from weakness of the gastric walls, or from continuous spasmodic contracture of the pyloric muscular sphincter.—*Edinburgh Med. Jour.*, November, 1898.

PROFESSOR TRIER'S LAST ILLNESS.—Prof. Trier, of Copenhagen, a man of sixty-seven years, who had always been in fair health, in February, 1898, began to notice that his strength was failing him, that his digestion was not as good as formerly, his skin became slightly yellow, and he somewhat emaciated. On making careless movements he would suffer from pains in the muscles of the legs and thighs. An examination revealed nothing abnormal in any organ whatever. In March, thinking that rest in bed would be beneficial, he took to his bed, when, on taking his temperature, he was surprised to see it 39°, and during his whole long illness it never descended to 37° but

twice, once after a dose of antipyrin, and the second time on the day of his death. The fever continued, with emaciation and anæmia. He was greatly disturbed by flatulence and somewhat by sleeplessness; his appetite was good till towards the last, but never a sign of vomiting. He was always very thirsty, but his tongue was never coated. Even the day before his death an examination was made, yet no diagnosis was arrived at. No albumin nor sugar in his urine, no enlargement of the spleen or liver, the heart wholly normal, etc. For several days before his death he had had a persistent hic-cough, and the afternoon of the day preceding his death a collapse set in, with a small pulse that seemingly pointed to an internal hæmorrhage. For a long time his evening temperature had been at  $39.7^{\circ}$ , to fall in the morning to  $38.5^{\circ}$ , so that typhoid fever was suspected. In the fourth week of his disease the temperature fell slightly, yet he remarked that in spite of this he felt still more relaxed and weak. That night of the collapse he was restless, and the next morning the radial pulse was not to be felt, while his extremities were cold. During this whole time his mind was clear. "How terrible such a condition of collapse is. I feel so very tired that I shall not live the day out." He passed away at 11.30 A.M. The necropsy revealed, besides an advanced arterio-sclerosis, a cancer, a sarcoma surrounding the aorta close up to the diaphragm, in the retro-peritoneal tissue. Our knowledge of cancers associated with rise of temperature is so scanty that I thought it worth while to abstract this case. His family history was wholly free from cancer. Miliary tuberculosis, Trier's own diagnosis, typhoid fever, endomyocarditis and pernicious anæmia had been discussed and thrown aside.—*Hospitalstidende*, No. 21, 1898.

**SEVERE CEREBRAL SYMPTOMS WITH GREAT DILATATION OF THE STOMACH.**—Prof. Th. von Juergensen reports the case of a man of 43 years, who, beyond weakness, gradually increasing debility and its consequences, but whose urine was wholly normal except scanty, developed symptoms which seemed decidedly uræmic, with succeeding death. The kidneys were found to be normal.—*Hospitalstidende*, No. 28, 1898.

**ARTERIO-SCLEROSIS—DISCUSSION IN THE SECOND SCANDINAVIAN CONGRESS FOR INTERNAL MEDICINE—August 12, 1898.**—Dr. Kl. Hansen called attention to our meeting with patients with radial arteries which were actual calcified tubes without the slightest symptom, clinically, not only of the moderate-sized blood-vessels, but also of the finest vessels, with interstitial connective tissue formation and parenchymatous changes, for example, in the myocardium, without associated symptoms. In contracted kidney he did not think that dilatation of the heart set in before the heart itself became sclerotic. He looked on arterio-sclerosis as a senile phenomenon as much as gray hair, and due to chemical processes, purely and simply. Hunger, privations and poor hygienic conditions particularly favor its development. In treatment have a watchful eye on the stomach. (Potain.) Dr. H. J. Vetlesen has seen several cases of sclerosis of the veins—phlebo-sclerosis. Arterio-sclerosis he regards as a precocious senility; he has seen it in a cancer patient of thirty. He supported Prof. Runeberg in the usefulness of the iodide of potash. He has also employed small doses of chloral hydrate, 0.20 ter die (Rokitansky), and has been impressed with the good results. Prof. Henschen views arterio-sclerosis as a poisoning, and particularly one by alcohol, or ptomaines, and

leucomaines. He does not think it a purely senile affair. Prof. Runeberg does not hold that the blood-pressure has any effect etiologically, and the attempt to explain the absence of hardening of the pulmonary artery on the ground of a low pressure there would not hold, as that has often been demonstrated, for example, in emphysema. Chemical states of the blood were at the bottom, and not senile changes.—*Hospitalstidende*, No. 37, 1898.

ACUTE NEPHRITIS FOLLOWING DYSENTERY; URÆMIA; SUBCUTANEOUS INJECTIONS OF SALT SOLUTION; RECOVERY.—Dr. V. Pateienko reports the case of a man of forty-four years who, convalescing from a dysentery of three weeks and five days' duration, was suddenly seized with frequent vomiting and serous diarrhœa, and cramps in his calves, arms and abdominal muscles, with such a weakening of his pulse that it became scarcely perceptible. Physiological salt solution (300 c.cms. at 40°) was injected subcutaneously. The pulse immediately improved, the diarrhœa and vomiting, together with the spasms, disappeared. The urine was found full of albumin, with many granular and blood-casts with red corpuscles and renal epithelia. He passed in twenty-four hours not over 100 c.cms. of urine. A diagnosis of acute nephritis following dysentery, with uræmic intoxication, manifested by the vomiting, spasms, serous diarrhœa and symptoms of hyposystolia, was made. The symptoms becoming aggravated again, 400 c.cms. of the salt solution were again injected, with the same happy effect as before. Later, two others were required, of 300 and 400 c.cms., respectively. After each one the heart gained in strength, the restlessness became less, the distressing hiccough ceased and the quantity of urine increased, finally to reach 2000 c.cms. in twenty-four hours. Then there was no albuminuria. A restoration to health followed, which was interrupted by a parotid abscess (incision). As he was strong and healthy before, the nephritis must have been due to the preceding dysentery.—*Medicinskoye Obozrenie*, August, 1898. I have seen a case of chronic diffuse nephritis develop slowly in an infant, my own, after a very severe attack of enterocolitis, at the age of four months. The general symptoms, as well as the chemical and microscopical examination of the urine, fully confirm the diagnosis. The child was robust and hearty before falling sick. "Morbis progrediens usque mortem; spes nulla; therapia nulla." That has been my experience in this case.—F. H. P.

SUDDEN DEATH FOLLOWING AN INJECTION OF ANTIDIPHThERIC SERUM FOR ASTHMA.—Prof. L. Revilliod, of Geneva, last year recommended injections of antitoxin in asthma. Dr. Combe, of Lausanne, in a girl of twelve years, who for a long time had suffered from very severe bronchial asthma, and whose heart was slightly irregular, injected 10 c.cms. of antidiphtheric serum (Roux's). She was dead in five minutes. The necropsy revealed a very large thymus gland compressing the trachea, a synechia of both lungs and an intense congestion of the bronchi. Though the cause of death here is doubtful, in cases of asthma with irregular pulse one should beware of trying this treatment. The pathological finding, enlarged thymus, was interesting, for it is recognized that in children this may become a cause of sudden death. Tracheotomy will not relieve.—*La Semaine Médicale*, No. 40, 1898.

ATROPIN IN ŒDEMA OF THE LUNGS.—Dr. Sticker thinks that atropin is of value in the treatment of œdema of the lungs complicating cardiac asthma,



and that particularly in the beginning, where the profuse secretion of mucus and rattling in the trachea threaten to develop into the feared œdema. The lower portions of the lungs may be noticed to clear up under its use.—*Muenchener Medicinische Wochenschrift*, No. 39, 1898.

**A CASE OF EPILEPSY FOLLOWING A LONG-LASTING DOUCHE TO THE HEAD.**—Dr. Max Breitung, of Coburg, reports the case of a boy of ten years who on a hot July day ran about a quarter of a mile to a bath-house, and who, while warm, exposed his head for at least fifteen minutes to the action of a cold douche. That evening he was excited, slept badly, and the next morning he suddenly was seized with an epileptic attack. No epilepsy had been known in either side of the family, and it was thought that the attack would not recur. Yet it did six or eight times the following year, and often since then. He is now sixteen.—*Deutsche Medicinische Wochenschrift*, No. 39, 1898.

**DIAGNOSIS OF MALARIA FROM MICROSCOPIC EXAMINATION OF THE BLOOD.**—Dr. F. Plehn, of Kamerun, Africa—a German Colony on the middle west coast—advises the following method for detection of the malarial parasite: rub the tip of the finger or the lobe of the ear well off with ether, make a quick puncture with the tip of a small lancet, and catch the drop of blood between two cover-glasses lying side by side, which are held over the exuding drop, the blood crawling up by capillary attraction. The glasses are then slid deftly off one another and laid, with a thin layer of blood on each, in the air to dry. Then they are placed in absolute alcohol, to fix the layer of blood, for three or four minutes, after which they are allowed to color for about an hour in a solution of methyl-blue and eosin, methyl-blue in a concentrated solution and a one-half per cent. solution of eosin, both made with water. The glasses are washed off with water, dried, and embedded in Canada balsam or gum arabic. Immersion and Abbe's illuminating apparatus are necessary, if one will obtain good reliable results. If one would recognize the little crescents, they must be magnified from eight hundred to one thousand times. The small crescents stain with difficulty. The larger and pigmented forms are easily recognized, unstained, in the freshly-drawn blood. The unpigmented forms are diagnosed with difficulty; yet they are characteristic of the severe forms of the disease.—*Die Kamerun Kueste*, Berlin, 1898.—I have been able this fall to differentiate several cases of beginning intermittent malarial fever from typhoid by examination of the blood, at the office. With a needle in a holder, which has been dipped into pure carbolic acid and then wiped dry, I make a quick "jab" into the tip of the little finger, previously pinched for a moment between my thumb and forefinger. Allowing the blood to flood out freely without pressure, which distorts the shape of the red blood-corpuscles, I catch a drop on a clean cover-glass and drop it carefully onto a slide. Then pressing the blood into a thin layer, I absorb that oozing out at the sides with a wisp of blotting-paper and examine unstained. The small and pigmented crescents will be easily seen near the edge of the corpuscle, possibly extending around half the circumference, or the parasites are present as little dots scattered throughout the whole corpuscle. At other times they will be noted as a host of small comma-like bodies filling the erythrocyte. In this way one may easily make a satisfactory diagnosis, and take the proper measures before the disease has progressed far. A commencing typhoid is thus quickly made out or excluded.

FRANK H. PRITCHARD, M.D.

SEPTIC PERITONITIS AND ITS SURGICAL TREATMENT.—Cobb (Boston) believes that operation in many cases of general septic peritonitis is far too often regarded as hopeless interference. A study of the pathology and bacteriology should show plainly that the surgical treatment in most cases is *obligatory*, and also that there can be consistently only one method of combating the infection by operation.

Peritonitis is always caused by bacterial invasion. It may be suspected that there are cases of peritonitis the causative organisms of which cannot be isolated by our present culture methods, and there is no question that some peritoneal infections are so virulent that death results so promptly that none of the usual signs of peritonitis are evident post-mortem.

Reichel ascribes many sudden deaths after abdominal operations to such virulent infections. He cites two cases of his in which he made a post-mortem one hour after death, and found no signs of peritonitis, but cultures from the shining peritoneal surfaces gave active bacterial growth.

All the forms of pyogenic cocci have been found in the exudation of general peritonitis. The streptococcus is the organism most to be dreaded, although under certain conditions the colon bacillus may be possessed of equal primary virulence. The staphylococcus albus is least virulent, and this organism, as also the citreus and the aureus, are often found in association with colon bacilli or streptococci. At times the aureus can cause a very virulent peritonitis.

The colon bacillus and its kindred, the bacillus lactis ærogenes and the bacillus fetidus (for these two are admitted to be practically identical with the colon bacillus), are not as yet entirely beyond dispute as causative agents of peritonitis.

It may be that the colon bacillus is the vigorous, highly resistant organism that overgrows the causative germs, the absorption of which is already causing toxæmia. In general peritonitis from perforation of a typhoid ulcer the typhoid bacillus has never been found, but in most of the cases colon bacilli have predominated, and in others pyogenic cocci. Kline found typhoid bacilli in the pus of a localized peritonitis after typhoid. Körte found typhoid bacilli in a case of general peritonitis originating from a suppurating mesenteric gland in the course of typhoid fever, but not from intestinal perforation. This is of certain significance as supporting the theory that in peritonitis from intestinal perforation the causative germs may be overgrown by the other bacteria of the intestinal canal. Recent observers, however, are united in deciding that in many cases the colon bacillus is possessed of great primary virulence.

Elting and Calvert, in a study of perforative peritonitis in dogs, found that the intense hæmorrhagic peritonitis present in all cases gave definite bacteriological results in twenty cases out of twenty-two. In eighteen cases members of the colon group were found, four times alone and fourteen times in association, streptococci once alone and seven times in association. Staphylococcus albus was found in five cases, but never alone; staphylococcus aureus once alone and three times in combination. In these cases cultures were made in from six to twenty hours after perforation, and the colon bacillus was the predominant organism.

The pneumococcus can cause peritonitis. This infection may occur without the association of pneumonia. It is undoubtedly a rare infection, but may be extremely virulent.

Gonococci are incapable of causing peritonitis. The weight of evidence goes to show that gonococci alone are harmless to the peritonæum; "gonorrhœal peritonitis" is a misleading expression. The bacillus *ærogenes capsulatus* has been found in a few cases of perforative peritonitis. It is not pyogenic alone, but in the presence of pyogenic organisms may be the main cause of death.

A very rare cause of peritonitis is infection by the bacillus *proteus vulgaris*. Only one case has been found, that reported by Flexner, of Johns Hopkins. This is the putrefactive organism found post-mortem in great numbers, and under normal conditions is not pathogenic to man. This case was most carefully studied by Flexner, and he seems to prove beyond a reasonable doubt that the infection was primary, and not a post-mortem invasion.

The anatomico-pathological varieties have been best classified by Pawlowsky:

(1) An extremely toxic variety, the "mycotica," in which death may occur before reactive inflammation takes on the peritoneal surfaces. In some cases the peritonæum may be covered with a slimy fluid containing a few blood corpuscles, small flakes of fibrin and many bacteria. There is no doubt that cases of such virulent infection occur that death results in a few hours with all the symptoms of shock.

(2) An infection of great virulence is also manifest in the hæmorrhagic form, characterized by hæmorrhagic extravasations and ecchymoses on the peritoneal surfaces of varying extent—with the intestinal coils markedly injected and distended—by a thin, brownish fluid exudation, in which are pus corpuscles and masses of bacteria and fibrin, and by fibrin flakes on the peritonæum. This is the common form met with in intestinal perforation.

(3) Fibrino-purulent and sero-purulent peritonitis, characterized by thin, sero-purulent exudation, with flakes of fibrin floating through it and masses of fibrin on the peritoneal surfaces. This form is the first stage (according to Pawlowsky) of purulent peritonitis—the sero-purulent fluid is made up chiefly of pus corpuscles and bacteria.

(4) Purulent peritonitis—a form characterized by an abundant purulent exudation of varying consistence.

The less serious forms of peritonitis are the fibrino-purulent and the purulent, the most virulent the hæmorrhagic forms. The purulent forms are of longer duration, and may be caused by less virulent organisms or by smaller amounts of infection.

Under abnormal conditions bacteria possessed of little or no pathogenic power may cause a rapidly fatal peritonitis. In any condition where the fluids of the body depart from normal, where the vital resistance of the tissues is lessened and the peritonæum damaged, an infection usually of lesser moment may cause the gravest clinical picture. Such conditions are especially chronic renal or hepatic disease, with or without ascites.

Perforation of the intestine is the commonest cause of the rapidly fatal hæmorrhagic forms of peritonitis, yet in intestinal perforation any form of peritonitis may be found.

A knowledge of the histology of the normal peritonæum and how fluids and solid particles are taken into the lymph and blood systems is of the utmost importance to the abdominal surgeon, and a clear understanding of the changed conditions in a more or less general peritoneal infection is of the greatest moment in the surgical treatment of peritonitis.



All careful investigators are agreed upon the following points:

(1) The absorption of fluids by the peritonæum is enormous. In an hour it will take up from three to eight per cent. of the body weight, but under the influence of toxic or irritant substances an equal transudation into the peritoneal cavity may take place.

(2) Over the *centrum tendinosum* of the diaphragm, between the connective-tissue fibres of the diaphragmatic peritonæum, open spaces are situated measuring from four to sixteen millimetres in diameter, and grouped in collections of fifty to sixty. These lymph spaces exist nowhere else in the peritonæum, and through these the greatest absorption of both fluids and solid particles takes place. Fluids may pass through the endothelium in many places, but the solid particles are absorbed only by these lymph spaces in the diaphragm.

(3) Minute solid particles are carried from the peritoneal cavity through the diaphragm into the mediastinal lymph vessels and glands, and thence into the blood circulation, by which they are distributed to the abdominal organs, to appear later in the collecting lymph glands of these organs. Larger sterile solid bodies are partly absorbed and the remainder encapsulated.

(4) The leucocytes are very largely the bearers of foreign bodies from the peritoneal cavity into the mediastinal lymph glands.

(5) There is normally a force or current in the peritoneal cavity which carries fluids and foreign particles from the pelvis toward the diaphragm, regardless of the posture of the animal (though gravity can retard or favor the current greatly).

Muscattello used carmine granules suspended in solution in his experiments, and his work proves that bacteria and all solid particles gain entrance to the system only through the lymph channels of the diaphragm and the mediastinal glands.

This absorption by the normal peritonæum is nature's safeguard against septic peritonitis. Colonies of bacteria are foreign particles that are absorbed by these lymph spaces, just as are the carmine particles in Muscattello's experiments.

It is well known that certain amounts of bacteria will be taken care of by the peritonæum without peritonitis, if it is normal structurally when the infection is introduced. The ability to remove bacteria and their products depends upon the kind and amount of infection, upon the systemic condition of the individual, upon the integrity of the peritonæum, upon the unobstructed condition of the diaphragmatic openings, and upon the presence or absence of culture media in the peritoneal cavity.

The conclusions of experimenters can be thus briefly stated:

(1) Normally the peritonæum can dispose of bacteria in varying amounts, depending on the virulence of the organism, without producing peritonitis, and the less the absorption from the peritoneal cavity the greater the danger of infection.

(2) Death may result from general septicæmia, and not peritonitis, where large quantities of bacteria or bacteria of special virulence are taken up by the lymph channels.

(3) Irritant material or trauma, which destroys or injures the peritoneal surface, even in limited area, prepares a place for lodgment of germs which may be the starting-point of peritonitis.

(4) Stagnation of degenerated fluid in dead spaces favors the growth of organisms, and the presence of infected blood-clots is specially liable to cause peritonitis.

(5) Injury to the abdominal viscera, as strangulation of an intestine, constriction and ligation of larger areas of tissue in the presence of pyogenic organisms, will almost certainly be followed by peritonitis.

In general peritonitis or severe inflammatory conditions of the peritonæum the lymph channels of the diaphragm are completely choked by masses of bacteria, free and enclosed in leucocytes; these, by their mechanical obstruction, and also by setting up inflammation in surrounding tissues, thoroughly prevent absorption.

Pawlowsky has shown that this obstructed condition of the lymph channels always occurs, and has illustrated it very beautifully in a series of plates. Just as, in Muscatello's experiments, the absorbing channels of the peritonæum were filled with carmine granules, so in Pawlowsky's they were choked with bacteria and *débris*. This obstructed condition of these all-important absorbing channels occurs very early.

Clark, of Johns Hopkins, accepting the facts of absorption and disposal of small amounts of infection by the normal peritonæum, reasoned that slight infection occurring in the course of abdominal operations, such as contamination with pus, or blood, or septic fluids, would be taken care of by the absorptive channels of the peritonæum better than by intraperitoneal drainage. He maintained that drainage was used far too often, and that the normal peritonæum could take care of moderate contamination, if given favorable conditions, without drainage. The method advised by him for operations in which there had been septic contamination of a previously normal peritonæum, or where raw and oozing surfaces were to be left, was to wash out the abdominal cavity thoroughly with gallons of hot salt solution, leave in the peritoneal cavity 500 to 1000 c.c., close the abdominal wound without drainage, and place the patient for twenty-four hours with the pelvis elevated. By this technique he washed out most of the infection, and by filling the abdomen with salt solution and elevating the foot of the bed he followed the known facts of Muscatello's experiments, namely, that there are currents in the intra-peritoneal cavity carrying particles to the lymph spaces in the diaphragm, which currents are best favored by gravity. This method Clark called "postural drainage."

Clark's article has been misunderstood by many, and in so far as misunderstood has done great harm. Several men have used this method in extensive local septic conditions, and also in general septic-peritonitis. It is distinctly stated by Clark, and also by Finney, that this method must not be used in septic peritonitis, but that in such conditions free drainage is demanded. All experimental evidence proves that in a very few hours the absorbing channels of the diaphragm are clogged with *débris* and bacteria—they have already taken to the glandular system as much infection as the individual can withstand, and their function will be only to slowly add to this by small amounts as the hours go on. They are no longer the open ways through which a small infection may be rushed into the glandular and blood systems and be rendered harmless.

The keynote of the treatment of general septic peritonitis must be the relief of the peritonæum and these obstructed lymph channels, and this can

only be done by removal of the septic exudation and subsequent drainage. Within five years opinions as to washing out and drainage have varied, but at the present time there is no uncertainty. Von Winckel, in his recent monograph on peritonitis, shows how those at one time denying the value of irrigation and drainage have been converted.

The treatment by injections of antistreptococcus serum is as yet experimental and inconclusive, Wallick concluding that its use had not modified the mortality.

Peritonitis associated with acute septic inflammation of the gall-bladder has been thus far uniformly fatal when operated upon. The infection is usually streptococci or colon bacilli, and is of extreme virulence.

Abbe has suggested that albumin in the urine of peritonitis cases is a contra-indication to operation. There is no way of verifying this statement, because of incomplete reports, but it cannot always hold true, for one of Cobb's successful cases had albumin before operation. The point is worth investigating, however.

The methods of operating adopted by Körte, Finney and McCosh are very little different, and illustrate the best technique to be employed. All use very free incision, median or lateral, fully exposing the peritoneal cavity, and in some cases make an additional cut in the right or left flank for further exposure and drainage. All remove the intestines from the abdominal cavity if the patient is not absolutely moribund, keeping them warm with hot towels and hot salt solution irrigation, and cleansing them and the peritoneal cavity as thoroughly as possible by very free irrigation and by gentle wiping with gauze pads.

Finney pays special attention to wiping off the flakes of fibrin from the intestines and wiping out the abdominal cavity, and especially the pelvis. McCosh does this, but lays stress on irrigation.

If the distention of the intestinal coils is too great to permit replacing them in the abdominal cavity, multiple aspiration or incision of them is done, with subsequent suture. Salt solution at a temperature of 112° to 114° F. is the irrigating fluid used. All use drainage: Körte, gauze, or rubber tubes and gauze; McCosh, gauze or strips of silk; Finney, gauze; McCosh injects an ounce of Epsom salts into the ileum with a large aspirating needle, closing the puncture with a Lembert stitch before replacing. It is stated by all that few cases are so desperate as not to permit these extensive procedures. These details are proven wise by experiment and investigation.

The use of chemicals, such as peroxide of hydrogen and corrosive sublimate, which is advocated by certain surgeons, is shown plainly to be wrong by Thompson and by Walthard. From their experimental work it is certain that even weak solutions of corrosive can of themselves cause peritonitis, and that sterile water is often irritating, but normal salt solution is not.

Cobb concludes his valuable paper by stating that more cases of general peritonitis are left to die unoperated upon than there are cases operated upon whose chances of life are destroyed by the operation. He does not claim that operation in septic peritonitis is ever more than a forlorn hope, but he does maintain that the operative treatment of this distressing condition is not undertaken as often as it should be, and when undertaken is often done in a half-hearted, incomplete manner.—*Boston Medical and Surgical Journal*.

HERBERT L. NORTHPROP, M.D.



**ACUTE GONORRHOEA TREATED BY PROTARGOL.**—(Neisser).—Protargol is a combination of silver with a proteid and contains 8.3 per cent. of silver. It is not precipitated in an aqueous solution, by albumin, dilute salt or hydrochloric acid solution, or by a soda solution. These peculiar qualities allow it to penetrate deep in the tissues. Neisser recommends antibacterial treatment as soon as possible after infection, and protargol has been the most certain and rapid remedy he has employed. He begins with a one-fourth of 1 per cent., increases soon to one-half of 1 per cent., and then to a 1 per cent. solution. There are scarcely any signs of reaction. The injections are given three times a day, twice for five minutes, and the third time the fluid remains in the urethra half an hour.

GEORGE R. SOUTHWICK, M.D.

**PROPHYLAXIS AND TREATMENT OF BLENNORRHOEA OF THE NEW-BORN BY PROTARGOL.**—Fuerst prefers protargol to nitrate of silver. Protargol is a preparation of silver, but is less easily decomposed, less irritant, easier to handle, and does not stain the clothing. It is best used in 10 per cent. solution made by rubbing up 10.0 of protargol with 10.0 glycerin into a paste, and this being dissolved in 90.0 of water.—*Fortschritte in der Medicin*, No. 4, 1898.

**LABYRINTHINE PHENOMENA DEPENDENT UPON MIDDLE-EAR DISEASES, AND THEIR RELIEF BY LOCAL TREATMENT.**—In a class of cases which have come under the author's observation, the history given pointed to some recent inflammatory process in the middle ear.

The lowest tones of the musical scale were well heard; the upper tone limit was either considerably reduced or normal, and bone conduction was either entirely absent or much below normal standard. Eustachian tubes were reduced in calibre, but air entered the tympanum easily upon catheterization. Inflation produced a harsh sound, indicative of the presence of mucus in the canal. Inflation frequently caused slight vertigo. Functional examination in these cases gave all the characteristics of a labyrinthine lesion.

The results of internal medication were negative. Immediate relief, however, followed the application of the Eustachian bougie. The author believes that rarefaction of the air within the middle ear may so alter the labyrinthine tension as to produce an actual traumatic affection of the labyrinth.

Where the Eustachian tube becomes suddenly occluded, from any cause, the sudden reduction of air pressure within the middle chamber may bring about a similar condition of increased labyrinthine concussion. If these cases are allowed to go without treatment organic changes occur in the labyrinth, and no improvement will follow the treatment of the middle ear.—E. Dench, *N. Y. Polyclinic Journal*, vol. x., No. 6.

**EXOPTHALMIC GOITRE TREATMENT BY MEANS OF GALVANISM.**—The constant galvanic current has given good results in the treatment of Basedow's disease. The principal advantages obtained with this electro-therapeutic method were the diminution or disappearance of the exophthalmus, gradual improvement of the general condition, diminution of the disordered cardiac innervation, and finally diminution in volume of the hypertrophied thyroid body.—E. Bertran, *Amer. Medico-Surgical Bulletin*, June 10, 1898.

HEREDITY AND THE DEVELOPMENT OF MYOPIA.—Wray, Charles, London, Eng. (*British Medical Journal*.) Report of the November, 1897, Meeting of the Ophthalmological Society of the United Kingdom.

Mr. Wray began by stating that some observers found a family history in as many as 60 per cent. of their cases of myopia. On the assumption that one-fourth of the hereditary tendencies were from each parent, and one-sixteenth from each grandparent, it was plain that hereditary predisposition would appear more and more in the ætiology of myopia. He questioned the expediency of using the term "acquired myopia" lightly, as no case could legitimately be called acquired unless ancestral myopia could be disproved, which the author contended was impossible. He next submitted that authorities repudiated the possibility of the transmission of acquired structural peculiarities, and experimental evidence was quoted to the effect that the removal of an eye in rabbits during many successive generations failed to cause the birth of one-eyed offspring. The author conceded the transmissibility of ordinary myopia, and then stated that there was no relation between the sum of the myopia of myopic parents and the amount that would appear in the offspring, and when the highest grades had been found the parental myopia was invariably confined to one parent.

Since Fukala's operation has come into vogue, the author had given special care to the investigation of the antecedents of such parents, and found in a considerable number of cases that the child with high myopia had suffered from protracted infantile marasmus, whilst the brothers and sisters who escaped had not. He further stated that out of 126 cases of myopia of over 10 D., he had not found one instance in which parent and child were both subject to an equal, or approximately equal, amount. The existence of the highest grade of myopia in one eye only made it exceedingly probable that other influences acted as powerfully as marasmus in the predisposed. Since such grave disproportions never arose in the limbs during the development, it was necessary to consider the difference in their development, and this was to be found in the way in which the vitreous was formed by the passage of mesoblastic elements into the secondary optic vesicle. Mr. Wray suggested the possibility of hypoinclusion being the basis of hypermetropia and excessive inclusion the cause of myopia. He alleged that this theory would explain the variation in the age at which myopia appeared, and the phenomena of stationary and progressive hypermetropia and myopia, as well as numerous other points in the pathology of myopia.

PARTIAL ATROPHY OF THE OPTIC NERVES FOLLOWING A CUTANEOUS BURN TREATED BY IODOFORM.—Albert Persion, Paris, after citing a case of this type, compares it with the retinitis and optic neuritis caused by the uremic condition following large surface burns.

From his studies he is led to believe that his case, as well as several others recorded by different authors, was a toxic condition caused by iodoform.

He believed that these cases may be of any grade, from an amblyopia with a central color-scotoma to a violent inflammation, or even an optic nerve atrophy.

The muscular fibres, he thinks, seem to be those that are first attacked.—*Archives d'Ophthalmologie*, October, 1897.

WILLIAM SPENCER, M.D.

## MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND  
THERAPEUTICS.

VERATRUM ALBUM AND VERATRUM VIRIDE.—According to Cartier, of Paris, veratrum viride has some points in common with and some points of difference from veratrum album. He finds that there is too much tendency to prescribe veratrum without the distinctive title, which is usually interpreted to mean veratrum album, thus ignoring the peculiar properties of veratrum viride. Both have cardiac debility, with cold sweat extremely marked. The white hellebore has this symptom much more marked than the green. Again, the white hellebore, through the active principle—veratrine—exhibits some symptoms of slowing the circulation and of paralysis of the muscles of the vegetative system, which brings about the characteristic coldness and throws in relief the homœopathic use. One notes among the symptoms the alternations of cold and heat, but veratrum album has never been indicated in febrile conditions or in congestions. Diarrhœa with coldness, a cholera-like condition of icy coldness, cardiac distress, with cold sweat—such are some of the more important characteristics of veratrum album.

Veratrum viride has a more extended action. Besides the state of collapse, the relaxation of the muscular tissues and the coldness which it has in common with its congener, it has also in marked degree the opposing phenomena, that is to say, the reaction of congestion; and we usually see veratrum viride recommended in acute inflammatory fevers, where it is better than in the cholera-like coldness. These two conditions are badly defined and badly interpreted in the materia medica of the green hellebore. Instead of indications for symptoms so different, one had best connect this drug in maladies which present both extremes; that is, affections which have great fluctuations of temperature.—*Medical Counselor.*

THE THERAPEUTIC USES OF CUPRUM.—From the symptoms developed in its provings, Evans, of Chicago, deduces the fact that the influence of cuprum is chiefly expended upon the principal nervous centres. It is doubtful whether a purely inflammatory process is instituted by copper except where the dosage is tonic. The symptomatology points rather to an alteration in nerve tissue that manifests itself in impaired nutrition, cellular or general. A cachexia becomes manifest, in the presence of which the elements of the blood are changed, and chloro-anæmia is established quite similar to that caused by iron, and which has been cured by the use of the latter metal, and *vice versa*. The inflammatory and ulcerative changes taking place in the intestinal tract are evidently due to the impaired nerve supply to those organs, while the vomiting is plainly cerebral in character. The choleraic



state induced by cuprum is of a convulsive and paralytic nature, for tetanic contraction in any or all of the muscles or muscular organs is invariable.

It is in the cerebro-spinal tract that the convulsive effects of cuprum are most readily observed and its administration for these is so eminently successful. Every form of spasm with which we are acquainted is to be found in the pathogenesis of cuprum. The muscles of the face are spasmodically distorted, contraction of the muscular wall of the stomach causes the most excruciating colic, while constriction of the masseters, pharynx and œsophagus renders swallowing almost impossible, or drink descends with a gurgling sound. Spasm of the bronchial and thoracic muscles causes difficult breathing. Tetanic contraction of the muscles of the extremities is so great that they rise in lumps and knots, with intense pain in the arms or legs, while general convulsions testify to their cerebral origin. These latter are noticed to commence with contraction of the fingers and toes, which spread from one group to another, until the whole body is involved. Paroxysms of convulsive cough, with blueness of the face, show its similarity to whooping-cough; and it is also significant of their nervous origin that spasmodic coughing and vomiting are temporarily checked by a swallow of cold water. Cuprum has been employed by both schools of medicine in the treatment of epileptiform convulsions and chorea, and is also of service in uremic convulsions as well as those attacking diabetics. Repercussed or non-developing exanthema, causing general convulsions, have by the use of cuprum been enabled to make their appearance or reappearance on the skin by relieving the cerebral involvement and permitting the poison to expend itself upon the surface of the body.—*The Clinique*, August 15, 1898.

F. MORTIMER LAWRENCE, M.D.

**ASPARAGIN IN MITRAL INSUFFICIENCY.**—Dr. Bonino, of Turin, has found asparagin 3x of efficacy in mitral insufficiency in that it notably relieved in a relatively short time a case with irregularity of the heart, mitral murmur, rhonchus and bronchial respiration with which the patient, a woman of forty years, also had attacks of fainting and of coughing. The urine was red, scanty and turbid.—*Il Secolo Omiopatico*, No. 9, 1898.

**CALCAREA CARBONICA IN SCORBUTIC RHACHITIS.**—Dr. R. Day reports two cases of Barlow's disease—acute or scorbutic rickets—where the gums were spongy, and certain bones were swollen and painful with hæmorrhages from the gums. Calc. carb. 6x and cod-liver oil brought about a rapid amelioration.—*Journal Belge D'Homœopathie*, No. 4, vol. v., 1898.—I know of a case observed in a neighboring town, where an infant, raised on condensed milk, developed signs of this disease. Fresh cow's milk, with orange-juice, brought a cure in a short time. Baginsky dwells especially on the value of diet: milk, beef-juice, and orange or lemon juice.

**PAINS IN THE RIGHT HYPOCHONDRIUM.**—In those cases with pains in the right hypochondrium which radiate upwards under the right scapula, usually one of three remedies—*æsculus hipp.*, *chel.* or *kali carbon.*—will be indicated. In a case where with every menstrual epoch the patient suffered from a pain at the outer side of the right scapula, and where only pressure of a hard substance or pinching would relieve, *æsculus* brought about a cure.—*Il Secolo Omiopatico*, No. 9, 1898.

**TREATMENT OF PURULENT OPTHALMIA IN NEW-BORN CHILDREN.**—Dr. Goullon, of Weimar, in purulent ophthalmia neonatorum recommends the use of nitric acid, 1x, of which he adds ten drops to a saucerful of warm water. A compress wet with this solution is laid over the eyes and changed as soon as it dries. Internally, he administers merc. ruber 5x or merc. corr. After the beginning of the infection he employs hepar sulph., which suffices to arrest the disease in mild cases. This treatment has given him better results than the customary nitrate of silver solution, which in 20 per cent. of the cases is said to leave corneal opacities.—*Leipziger Populäre Zeitschrift fuer Homöopathie*, No. 6, 1898.

**TREATMENT OF DYSMENORRŒA.**—Dr. Pinart, of Barcelona, in the neuralgic form of dysmenorrhœa, with pain before menstruation and gastric disturbances, advises:

*Ammonium Carbon.*—Pains at certain regular hours, with congestive headache. *Asclepias tuberosa* is similar in its indications.

*Viburnum Opulus.*—Pains located in the ovaries.

*Cocculus* and *Colocythis.*—The same indications as *viburnum*, but with nausea and fainting attacks.

*Hamamelis.*—Pain in the right ovary.

*Viburnum Prunifolium.*—Pains in the uterus, and very intense.

*Caulophyllum.*—Very intense pains in the uterus, but coming on in the form of spasms or paroxysms like those of labor; there are spasms of other organs as well, especially of the larynx. This drug is a very precious remedy not only in the above cases, but also in spasmodic contraction of the cervix in labor or after confinement, or even in the metrorrhagia after parturition.

*Castoreum.*—Useful in women more or less nervous.

*Tarantula.*—A remedy which should not be forgotten, especially if there be choreic movements or hysteric symptoms. Hot applications to the abdomen or hot baths are useful adjuvants. In the congestive variety the symptoms in the beginning are: heaviness and distress in the pelvis (small) and small of the back, rectal tenesmus and burning on urination; finally, violent pains in these regions, with evacuation of a small quantity of menstrual blood. In certain cases it passes in small clots at first and later becomes more abundant. In these cases the chief remedies are bell. 30x and apis 6x, alternated. The former is indicated in the associated congestion and the latter for the œdema. Among other remedies one should remember kali carb. in young girls with anæmic symptoms, palpitation of the heart and very intense headache. If bell. does not relieve and there are neuralgias of different parts of the body, then try gelsem.

*Cactus.*—In cases associated with palpitation simulating angina pectoris.

*Cocculus.*—Drop by drop oozing of black blood with the other symptoms.

*Nux Vom.*—Associated constipation, with rectal and vesical tenesmus.

*Cuprum.*—Dysmenorrhœa with convulsions, especially of the lower extremities.

*Secale Corn.*—Extremities cold, with cold sweat.

*Xanthoxylum.*—Insupportable pains in the lower extremities, with dysmenorrhœa. In membranous dysmenorrhœa apis may be alternated with calc. carb. Another remedy in this condition is borax, which is regarded by some writers as a specific for sterility.—*Revista Medica de Barcelona*, 1898.

**FERRUM PHOSPHORICUM.**—Dr. Cartier in a study of this drug states that its nearest analogue is aconite; it stands between it and gelsemium. In anæmia it resembles china. In action on the respiratory organs it stands between ferrum and phosphorus. It is indicated in congestion of the lungs even if high fever complicate. Oppression and dyspnœa are present; oppression without dyspnœa also calls for the drug. In many ways ferrum phos. resembles bry., arn. and bell.; hepar sulph. and merc. also act similarly, especially in catarrhal otitis. It is particularly indicated in weakness and delicacy in children in cases where the muscles are firm, for sulph. suits only those with brunette complexions and flabby muscles (Schuessler). A more certain indication is rheumatism, where the muscles are stiff and feel as if paralyzed, with a tendency to cramps (strychn. phosph.). Kali mur. is very often indicated after ferrum phos. Aconite and ferrum phos. cannot be substituted for each other. Ferrum phos. will not abort a pneumonia as aconite may, at times, but it will control it and prevent its progression. It relieves the weakness of fever, and it appears to be borne better by weakly persons and children—better than aconite. (I find aconite to be well tolerated in large doses by children. Prof. Comby, of Paris, asserts that to get good results with aconite in children goodly doses of the tincture must be given.) Cowperthwaite thinks that too little is given. Rush of blood to the head; headache with a gouty predisposition (natr. sulph.); the head feels sore to the touch. Epistaxis in children (Hughes). Pharyngeal inflammation and a red, dry throat, with much pain; ferrum phos. decreases the fever, the blood streaked expectoration, in affections of the pharynx, larynx and trachea. In the first stage of febrile, inflammatory catarrh it is useful. Dr. Nimier claims that the remedy will perform actual wonders in dyspepsia, with a great desire for cold water or brandy and a disgust for all meat and milk. In diarrhœa in children in consequence of abdominal congestion where the stools are watery and follow each other tolerably rapidly, possibly with a little blood in them; the face of the child is red and there is stupor. Taking cold and abdominal congestion from suppressed sweat are the usual causes. There is never any tenesmus. Cystitis in its first stage may find its remedy here. They are fever, heat and pain; there is a characteristic aggravation on standing. The incontinence is characteristically diurnal, or in the sitting or standing position, and never on lying down. In acute febrile rheumatism it is a very good remedy, as well as in attacks of gout, with swollen joints, where it may be alternated with colchicum, if necessary. (Colchicin is one of the best, if not the best, remedies in acute articular rheumatism.) All the pains of this remedy are aggravated by movement and are ameliorated by cold. Ferrum phos. seems to be indicated in the first stage of typhoid fever and in all febrile states with a tendency to hæmorrhages and circulatory disturbances. In the hectic fever of consumptives it is especially indicated. After abuse of quinine in malaria its action will very often be crowned with success. In rheumatic fever the urine should be neutral or alkaline.—*Zeitschrift des Berliner Vereines Homœopathischer Ärzte*, Bd. xvii., Hft. 11, 1898.

**TREATMENT OF URÆMIA.**—Dr. B. Bailey, besides an appropriate milk diet in uræmia from functional disturbances, advises constitutional remedies, as sulph., calc. phos. and kali phos. In uræmia of true renal origin the lesion should be traced out and diagnosed. Treatment will differ according to the stage or form of the disease.



In the beginning, when there is an overburdening of the liver and an over-activity, and even a hypertrophy, of the heart, the chief efforts should be directed towards this organ, and notably with glonoine 4-6x, or one may attempt to eliminate the toxines by means of ars. 3-6x, merc. 3-6x and euonymin 1-3x, to recur later to constitutional drugs, as sulph., calc. phos. and kali phos. But at a later stage of the disease, when the heart is enfeebled and the blood impoverished, one must stimulate the heart with digitalis, strophanthus, adonis, cratægus or glonoine, to follow it with the other drugs mentioned. Elimination through the kidneys is preferable to pilocarpine and saline and other purges, which impoverish the aqueous elements of the body. He would rather advise enemata of cold water (recommended by Legendre, of Paris, in uræmia in little children to force the kidneys to act) or even a few leeches around the anus when the portal system is overloaded.—*Journal Belge d'Homœopathie*, No. 4, vol. v., 1898.

**ARSENICUM IODATUM IN PAPULAR ECZEMA.**—A little girl of twelve years, who had suffered for months from a papular eruption, which had gradually extended over the whole body. At night there was great itching; her appetite was good and her bowels were normal. In the course of six weeks she received sulphur, apis and graphites, but without visible results. The eruption would heal up in one place to break out in another. Under the influence of graphites the eruption became more squamous. At the same time she began to suffer from coryza, with discharge of a thin liquid from the nose; the nocturnal pruritus, however, did not become modified. She then received arsen. iodatum, with the result that in three weeks the skin irritation disappeared and the eruption dried up. Under the influence of the same remedy the eczema finally disappeared and the cure was permanent.—*Wratich Homœopat*, No. 9, 1898.

**A FEW CHARACTERISTICS OF RHUS TOXICODENDRON.**—This drug won its spurs in the treatment of rheumatism. It produces violent inflammation of the skin, the mucous membranes of the stomach and intestines, the serosa, and particularly those of the joints, and acts as a paralyzer of the brain, nerves, spinal cord. Thence one may see that it is also indicated in diseased conditions where life itself is as if paralyzed; for example, in typhoid fever and typhoid states. Characteristics are: in rheumatic pains in the scalp; rush of blood to the head, with a throbbing pain in the occiput as though the brain would burst. A scaly and scabby eruption upon the head of little children, with violent itching. Herpes zoster of the face. Urticaria-like eruptions. Rheumatism and rheumatic diseases. Sticking and drawing pains in the joints, with redness and swelling. The pains are worse during rest and feel better on slowly moving about (ferr. and pulsat.). Stiffness of the joints with a feeling as if paralyzed, with amelioration by slowly and steadily moving about. In the morning on rising the stiffness is worst. In paralyzed conditions of the limbs that have resulted from rheumatism, as well as in sprains, the tincture of rhus tox. externally, well diluted, has given good results.

Typhoid states, with great weakness, delirium, thirst and stupor, with a blackish tongue. The pains of this drug are worse at nights, on repose and on quickly moving about. Externally, it is diluted with alcohol, water or olive oil, in the proportion of one to ten.—*Homœopatisch Maandblad*, No. 9, 1898.

FRANK H. PRITCHARD, M.D.

# INDEX

TO THE

## HAHNEMANNIAN MONTHLY.

VOLUME THIRTY-THIRD, 1893.

	PAGE		PAGE
Abdominal Incision, A Suggestion to be Used in, . . . . .	535	Anasarca of Heart Diseases, Iodine in the, . . . . .	543
Incisions, . . . . .	267	An Expedient to Determine Posi- tively Whether a Communication Exists Between Fistulous Openings in the Lumbar or Hypogastric Region and the Bladder or Kidney, . . . . .	200
Abortion, Ergot in, . . . . .	540	Angina Pectoris, Iodine in Diseases of the Circulatory Apparatus, and Especially in, . . . . .	317
Treatment of. C. R. Norton, M.D., . . . . .	150	Anterior and Posterior Colpotomy. Newton M. Collins, M.D., . . . . .	153
Abscess of Superficial Tissues, Treat- ment of. D. P. Maddux, M.D., . . . . .	110	Antigalaetagogue, Camphor as a, . . . . .	266
Of the Temporal Bone. Ptosis as a Symptom in, . . . . .	572	Antimonium Tartaricum and Glyco- suria, . . . . .	272
Aconite and of Ferrum Phos. in Res- piratory Affections, The Use of, . . . . .	206	Antipyrine, The Symptomatology of, Antisudoral, Sage as an, . . . . .	478
In Influenza, . . . . .	332	A Physician's Property, . . . . .	127
Acromegaly, the Muscular Atrophies, Ataxic Paraplegia, and Cere- bellar Tumor, A Clinical Lec- ture on, Clarence Bartlett, M.D., . . . . .	81	Apis Mellifica, The Pathological Changes Induced by, . . . . .	79
Pathology of, . . . . .	67	Apoplectic States, The Diagnosis and Prognosis of Cerebral Hæmorrhage and, . . . . .	530
Acute Ascending Paralysis Occur- ring in the Course of Anterabie Treatment, . . . . .	131	Appendicitis During Pregnancy, . . . . .	660
Acutely Unconscious, The. Weston D. Bayley, M.D., . . . . .	107	in Young Children, . . . . .	533
Address Delivered at the Jubilee Commencement of the Hahne- mann Medical College of Philadel- phia, Academy of Music, May 12, 1898. Wm. Tod Helmuth, M.D., LL.D., . . . . .	347	Treatment of, . . . . .	322
After-Treatment of Peritoneal Sec- tion, The, . . . . .	603	with Illustrations and a Series of Microscopic Slides, Hepatic Abscess Due to an. Charles Becker, M.D., . . . . .	421
Albuminuria in Three Members of the Same Family, Intermittent Cyclic, . . . . .	458	Argentum Nitricum, . . . . .	672
Alcohol as a Disinfecting Agent, . . . . .	603	Arschagouni, Johannes, M.D. The Medical Treatment of the Sexual Passions, . . . . .	440
Alcoholism of the Father Upon the Vitality of the Child, Influence of, Alumina in Relaxed Mucous Mem- branes, . . . . .	51	Arsenicum Iodatum in Papular Eczema, . . . . .	800
Amblyopia, Congenital. W. H. Big- ler, M.D., . . . . .	33	Arterio-Sclerosis, Discussion in the Second Scandinavian Congress for Internal Medicine, . . . . .	786
A Misconception, . . . . .	258	Artificial Feeding of Infants with Synthetical Milk. C. Sigmund Raue, M.D., . . . . .	384
Ammonium Carb. in Uræmia, . . . . .	411	Ascites of Hepatic Origin, China in, Ashcraft, L. T., A.M., M.D. Causes and Prevention of Urethral Stricture, . . . . .	120
Amyl Nitrite Test, Chronic Anæmia of the Labyrinth and the, . . . . .	139	Diagnosis and Treatment of Ureth- ral Stricture of Large Cali- bre, . . . . .	305
Anacardium Neurasthenia, . . . . .	412	Asepsis or Antisepsis, . . . . .	475
Anæmia of the Labyrinth and the Amyl Nitrite Test, Chronic, . . . . .	139	Ashley, Maurice C., M.D. The Hy- giene of the Middletown State Homœopathic Hospital, . . . . .	286
of Lead Poisoning, The, . . . . .	607	Askenstedt, Fritz C., M.D. Bromo- form, . . . . .	50
Treatment of Pernicious, . . . . .	736		

	PAGE		PAGE
Asparagin in Mitral Insufficiency, . . .	797	Bladder, Treatment of Cystitis and	
Asthma, Iodine in Millar's, . . .	414	Catarrh of the, . . .	544
in Young Children. J. E. Bel-		Blennorrhœa of the New-Born by	
ville, A.M., M.D., . . .	509	Protargol, Prophylaxis and Treat-	
Sudden Death Following an Injec-		ment of, . . .	794
tion of Antidiphtheritic		Blind in the Country is Greater	
Serum for, . . .	787	than in Large Cities, Why the	
Astigmatism, Disappearance of, . . .		Proportion of, . . .	604
Ptosis after Correction of, . . .	138	Blood, Diagnosis of Malaria from	
Atropin-Conjunctivitis, . . .	667	Microscopic Examination of the, . .	788
in Edema of the Lungs, . . .	787	Blood-Stains, . . .	658
Atropine Rhinitis, . . .	668	Vessels of the Abdomen, Cases	
Atypical Gout, . . .	198	of Thrombosis and Embolism	
Aurum Triphyllum on the Larynx, . .	604	of the large, . . .	596
A Valuable Addition to the Materia		Bone, Fluoric Acid in Suppuration of,	416
Medica, . . .	477	Borax in Leucorrhœa, . . .	479
Bacteriology of Puerperal Infection,		Bottle in the Rectum, A . . .	266
The, . . .	730	Brain, A Case of Gumma of the Base	
of Rheumatism, The, . . .	401	of the, . . .	400
of Typhoid Fever, Suggestions		Brierly, F. Walter, M.S., M.D. The	
on the. Joseph C. Guernsey,		Treatment of Hæmorrhoids, . . .	650
A.M., M.D., . . .	220	Bright's Disease, A Few Hints for	
of the Vagina in Pregnancy, The,	731	the Treatment of, . . .	605
Bad-Naueim. A Glimpse "Before"		Semmola's Views on the Pa-	
and "After" Taking. A Pen-		thology and Treatment of.	
Picture of a Patient at. Ed-		George Frederick Laidlaw,	
ward R. Snader, M.D., . . .	491	M.D., . . .	376
Treatment of Heart Disease.		Therapeutics of Chronic. Clif-	
Edward R. Snader, M.D., . . .	1	ford Mitchell, M.D., . . .	102
Baily, A. W., M.D. Is the Present		Bromoform. Fritz C. Askenstedt,	
High Rate of Infant Mortality		M.D., . . .	50
Necessary? . . .	253	Brown, S. G. A., M.D. Carbuncle, A	
Baldness, Thallium for, . . .	607	Case, . . .	179
Baptisia in Typhoid, . . .	80	Brow-Presentations Into Facial by	
Barlow's or Moeller's Disease, The		Traction on the Upper Jaw, The	
Diagnosis of, . . .	522	Conversion of, . . .	407
Bartlett, Clarence, A.M., M.D. Clin-		Bufo Rana in Epilepsy, . . .	204
ical Lecture, . . .	627	Burns and Scalds, Homœopathic	
A Clincial Lecture on Acrome-		Treatment of. Joseph C. Guern-	
galy, the Muscular Atro-		sey, A.M., M.D., . . .	98
phies, Ataxic Paraplegia and			
Cerebellar Tumor, . . .	81	Cæsarean Section vs. Fœtal Mortal-	
Bayley, Weston D., M.D. The		ity, . . .	602
Acutely Unconscious, . . .	107	A New Incision for, . . .	328
Becker, Charles, M.D. Hepatic Ab-		The Fundal Section in the Con-	
scess Due to an Appendicitis, with		servative, . . .	731
Illustrations and a Series of Mi-		Vaginal, . . .	731
croscopic Slides, . . .	421	Calcareæ Arsenica. The Use of, . .	784
Beer and the Bicycle. Clifford		Carbonica in Scorbutic Rachitis,	797
Mitchell, M.D., . . .	439	Calibre, Diagnosis and Treatment of	
Belville, J. E., M.D. After Treat-		Urethral Stricture of Large. Leon	
ment of Cases of Tracheotomy		T. Ashcraft, M.D., . . .	305
for Laryngeal Diphtheria, . . .	448	Calomel, Poisoning by, . . .	129
Asthma in Young Children, . .	509	Camphor as an Antigalactagogue, .	266
Beri-Beri, Treatment of, . . .	466	Cancer, Chelidonium in, . . .	479
Betanaphthol-Bismuth, An Ideal		By Czerny and Truneck, Treat-	
Remedy in Diarrhœal Diseases. E.		ment of, . . .	202
G. Whinna, M.D., . . .	187	Of the Neck Complicating Preg-	
Betts, B. F., M.D. The Surgical		nancy and Labor, . . .	325
Treatment of the Irreducible		Cannabis Indica in Large Dose, Some	
Form of Uterine Antelexion.		Effects of, . . .	480
Illustrated, . . .	232	Cantharis in Dysentery, . . .	500
Bicycle, Beer and the. Clifford		Capsicum in Dysentery, . . .	508
Mitchell, M.D., . . .	439	Carbuncle: A Case. S. G. A. Brown,	
Bigler, W. H., M.D. Congenital Am-		M.D., . . .	179
blyopia, . . .	33	Carbolic Acid in Eczema, . . .	140
Bladder when Associated with Hy-		Cardiac Arrhythmia and Their Treat-	
pertrophied Prostate, Remarks on		ment, Different Forms of, . . .	132
the Treatment of Stone in the, . .	469	Remedies. A Few, . . .	129
		Carotid Artery, Punctured Wound of	



	PAGE		PAGE
the Common. H. L. Northrop, M.D.,	712	Cinnabar in Balano-Posthitis, . . .	768
Castration in Women, The Physiological Effects of, . . .	202	Circulatory Apparatus in Diphtheria, The Clinical Symptoms of, . . .	468
Cataract in Glass-Blowers, . . .	475	Circumcision or Dilatation, . . .	535
Iodide of Potassium in, . . .	330	Of Girls, . . .	536
The Treatment of Senile, . . .	669	Citrate of Silver (Itrol) for Gonorrhœa, . . .	529
Catarrh of the Upper Air-Passages, For Inhalation in, . . .	203	Clapp, J. Wilkinson, M.D. Comparative Strength of Tinctures, . . .	737
Causa Causarum, . . .	191	Climacteric Neurasthenia, Lachesis in, . . .	540
Cause, A Case of Tetanus from a Rare, Causes and Prevention of Urethral Stricture. L. T. Ashcraft, A.M., M.D., . . .	120	Clinical and Bacteriological Study of Some Forms of Conjunctivitis in Children, . . .	727
Cauterization with a Hot Iron Protection Against Infection? Is, . . .	474	Certainities, Frank N. Pritchard, M.D., . . .	636
Cerebral Congestion, Glonoin in, . . .	144	Certainities, W. S. Searle, M.D., . . .	170
Hæmorrhage and Apoplectic States, The Diagnosis and Prognosis of, . . .	530	Diagnosis of Scrofulosis, . . .	70
Symptoms of Sanguinaria Canadensis, The, . . .	620	Forms of Pulmonary Tuberculosis, The, . . .	593
Symptoms with Great Dilatation of the Stomach, Severe, . . .	786	Lecture, Clarence Bartlett, A.M., M.D., . . .	627
Cerebro-Spinal Canal in the New Born, Hæmorrhages in the, . . .	56	On Various Forms of Stupor, Unconsciousness and Coma, with the Differential Diagnosis and Emergency Treatment, A Clinical Lecture. Walter Sands Mills, M.D., . . .	573
Celiotomy, Suture Materials and Methods in, . . .	321	Significance of the Discharges in Infantile Diarrhœa, . . .	130
Cervix, Laceration of the, . . .	405	Cobb, Joseph Pettee, M.D. Nutrition, . . .	553
Chelidonium in Cancer, . . .	479	Cocaine Anæsthesia in Perineorrhaphy, . . .	200
Child, A Case of Chronic Diffuse Nephritis in a. Frank H. Pritchard, M.D., . . .	776	Cocculus in Vertigo, . . .	541
Childhood, The Diathetic Diseases and their Influence Upon the Course and Treatment of the Acute Illnesses of. C. Sigmund Raue, M.D., . . .	763	Colchicum in Chronic Diarrhœa, . . .	735
Children, Appendicitis in Young, . . .	533	"Colds," Hepar Sulphur in, . . .	670
Asthma in Young. J. E. Belleville, A.M., M.D., . . .	509	Collins, Newton M., M.D. Anterior and Posterior Colpotomy, . . .	153
The Homœopathic Treatment of Pneumonia in, . . .	608	Colpotomy, Anterior and Posterior. Newton M. Collins, M.D., . . .	153
Indicanuria in Diseases of, . . .	400	And the Surgical Treatment of Pelvic Diseases, . . .	268
The Psychology of the Vision of, . . .	409	And the Total Extirpation of the Uterus, . . .	76
The Safest Hypnotic for, . . .	727	Comparative Strength of Tinctures. J. Wilkinson Clapp, M.D., . . .	737
Some Diarrhœal Diseases in, . . .	403	Comparison Between Indication of Premature Labor and Symphysectomy in Contracted Pelves, with Diameter of 8.5 to 9.5 c. m., . . .	474
Tachycardia and Exophthalmus in. E. M. Hale, M.D., . . .	145	Comparison of Rhododendron and Rhus Tox. William D. Young, M.D., . . .	769
Childhood, Chronic Interstitial Nephritis During, . . .	196	Congenital Constipation, . . .	783
The Diagnostic Value of Heart Murmurs in, . . .	593	Conjunctival Sac to the Anterior Chamber, The Influence of Holo-cain upon Diffusion of Fluids from the, . . .	668
China in Ascites of Hepatic Origin, Chopcheenee in Syphilis, . . .	78	Conjunctivitis in Children, Clinical and Bacteriological Study of Some Forms of, . . .	727
Christine, G. Maxwell, M.D. A Few Thoughts on the Surgical Phase of Obstetrics, . . .	156	Nature of Vernal, . . .	331
Chronic Cystitis, The Therapeutics of, . . .	272	Constipation of One Month's Duration, . . .	197
Interstitial Nephritis During Childhood, . . .	196	Treatment of, . . .	672
Inversion of the Uterus, Treatment of, . . .	472	Contribution to the Study of Secondary Laparotomy, . . .	137
Ciliated Cells, The Importance of, . . .	401	Conversion of Brow-Presentations Into Facial by Traction on the Upper Jaw, The, . . .	407
Cimicifuga in Noises in the Ears, . . .	736		
Cina in Enuresis Nocturna, . . .	542		
Homeopathic Uses of, Charles Mohr, M.D., . . .	47		

	PAGE		PAGE
Cough Remedy, Phosphorus as a, . . .	208	Deacon, Edward Magee, M.D. Retained Faecal Matter, Its Relation to Diseases of the Alimentary and Genital Tracts, and Its Treatment, . . .	300
Coughs of Ramex and Nux Vom., . . .	270	Deafness, . . .	476
Cowperthwait, E. G., M.D. Uremia and Its Treatment, . . .	437	Defecation in Infants, The Causes of Difficult, . . .	406
Cramps, Cuprum in Muscular, . . .	208	Dengue, Treatment of, . . .	204
Cranch, Edward, Ph.S., M.D. Gelsemium Sempervirens, . . .	117	Drug Selection in the Treatment of Tubercranial Hæmorrhage, . . .	206
Creosote, Puerperal Septicæmia Treated by Hypodermic Injections of, . . .	600	Dudley, Pemberton, M.D. Homeopathy: Its Origin, Meaning and Scope, . . .	545
Croup, Treatment of Membranous, . . .	78	The Preparatory Educational Needs of the American Medical Student, . . .	337
Cuban Campaign, Malaria and the, . . .	465	Dysentery, Cantharis in, . . .	500
Cuprum in Muscular Cramps, . . .	208	Capsicum in, . . .	508
The Therapeutic Uses of, . . .	796	Nux Vomica in, . . .	510
Cystitis and Catarrh of the Bladder, Treatment of, . . .	544	Dysmenorrhœa, Treatment of, . . .	793
And Pyelitis, the Differential Diagnosis of, . . .	660	Dyspepsia, Heart Disturbances in, . . .	265
The Therapeutics of, . . .	207		
Diabetes Mellitus on the Female Sexual Organs and their Functions. The Effect of, . . .	537	Early Pathognomic Signs of Tabes Dorsalis, . . .	401
Diabetic Retinitis, . . .	269	Ear Diseases, and Their Relief by Local Treatment, Labyrinthine Phenomena Dependent Upon Middle, . . .	794
Diagnosis of Diseases of the Upper Rectum and Sigmoid Flexures, . . .	404	Manifestations in General Diseases, . . .	329
Of Middle Ear Tuberculosis, . . .	657	Muscles of Accommodation, . . .	558
Of Small-Pox and Measles, Differential, . . .	320	Tuberculosis, Diagnosis of Middle, . . .	657
Of Stone in the Bladder by Skiagraphy, . . .	666	Ears, Cimicifuga in Noises in the, . . .	733
And Treatment of Urethral Stricture of Large Calibre, Leon T. Ashcraft, M.D., . . .	305	Myasis of the Nose and, . . .	533
Diarrhœa, Clinical Significance of the Discharges in Infantile, . . .	130	Eclampsia, A Case of Extra-Uterine Pregnancy with, . . .	326
Colehium in Chronic, . . .	735	Eczema, Arsenicum Iodatum in Papular, . . .	800
Diarrhœal Diseases, Betanaphthol-Bismuth, An ideal Remedy in, E. G. Whinna, M.D., . . .	187	Carbolic Acid in, . . .	140
Diseases in Children, Some, . . .	403	Kreosotum in, . . .	271
Diathetic Diseases and their Influence Upon the Course and Treatment of the Acute Illnesses of Childhood, The. C. Sigmund Rane, M.D., . . .	763	EDITORIALS—	
Diazo-Reaction in Nursing-Children's Urine, The, . . .	469	A Misconception, . . .	253
Different Forms of Cardiac Arrhythmia and Their Treatment, . . .	132	A Physician's Property, . . .	127
Digitalis Tablets Inert, . . .	304	Causa Causarum, . . .	191
Diphtheria, After Treatment of Cases of Tracheotomy for Laryngeal, J.E. Belville, M.D., . . .	448	Congenital Constipation, . . .	783
Antitoxin Promptly and Boldly, Use, . . .	661	Homœopathic Methods, . . .	780
Myrrh in the Mixed Infection of, . . .	398	Keep Cool, . . .	591
The Medical Treatment of, . . .	410	Male or Female, . . .	125
Two Peculiar Cases of, Frank H. Pritchard, M.D., . . .	511	Medical College Education, . . .	312
Diphtheritic Paralysis, The Treatment of Post, . . .	411	Medical Results of the War, . . .	459
Disappearance of Ptosis after Correction of Astigmatism, . . .	138	Military Hygiene, . . .	588
Diseases of the Eye Dependent on Epidemic Influenza or Grip, . . .	269	New Year's Resolutions, . . .	57
Disinfecting Agent, Alcohol as a, . . .	603	Our Graduate, . . .	397
Disinfection of the Hands, The, . . .	408	Pharmacopeia, . . .	781
Of the Sick Room and Clothing, . . .	193	Probabilities, . . .	654
		Telling Facts, . . .	722
		The American Institute at Omaha, . . .	395
		The Army and Navy Forever, . . .	392
		The Golden Jubilee of Old Hahnemann, . . .	398
		The Hahnemann Monument, . . .	263
		The Meetings of the Pennsylvania and New York Societies, . . .	587
		The Omaha Meeting, . . .	528
		The Semi-Centennial of Hahnemann Medical College, Philadelphia, . . .	262
		The X-Rays in War, . . .	590

	PAGE		PAGE
EDITORIALS—		Phosphoricum, The Therapeutic	
There is Balm in Gilead, . . .	523	Range of, . . .	415
There is no Great and no Small,	721	Few Thoughts on the Surgical Phase	
There is Nothing Hidden But		of Obstetrics. G. Maxwell Christie,	
Which Shall Be Revealed, . .	62	M.D., . . .	156
Elbow-Joint, Treatment, Fracture of,	535	Fibroid Tumors of the Uterus? When	
Endometritis, Soluble Silver Bougies		is Operation Justifiable for, . . .	323
for the Treatment of Catarrhal, . .	473	Fibroids, A New Remedy for, . . .	731
Enteric Fever, Throat Lesions in, . .	149	Fibrous Tumors of the Uterus, . . .	264
Eauresis Nocturna, . . . . .	605	Fluoric Acid in Suppuration of Bone,	
Nocturna, Cina in, . . . . .	540	in Whitlow, . . . . .	669
Epidemic Disease? Is Sunstroke an,	663	Fœtal Mortality, The Cæsarean Sec-	
Epilepsy, Bufo Rana in, . . . . .	204	tion vs., . . . . .	602
Following a Long-Lasting		Forceps, Especially in Narrow Pel-	
Douche to the Head, A Case		ves, The Use of, . . . . .	536
of, . . . . .	788	Formaldehyde in Hay Fever, . . .	668
Its Indications and Consequen-		Fracture of Elbow-Joint, Treat-	
ces, Surgical Treatment of, . . .	134	ment, . . . . .	535
On the Treatment of, . . . . .	414	Fractures, Œdema in, . . . . .	124
A Report of Two Cases of Treph-		Fragmenta, Absinthium, Antipyrin,	
phining for. Sidney F. Wil-		Arsenite of Copper, Borax, Carbolic	
cox, M.D., . . . . .	273	Acid, Erigeron Can., hyosciamine,	
Statistical Study in, . . . . .	132	hydrobrom., Iodine, Terebinth, . . .	333, 334
Epistaxis, Plugging in Severe, . . .	330	Fries, Charles J. V., Ph.D., M.D. The	
Ergot in Abortion, . . . . .	540	Treatment of Scarlatinal Neph-	
Euonymus, Partial Proving of, . . .	480	ritis, . . . . .	451
Euphthalmic and Mydriatics of		"Frog-Girl," an "Angle-Worm Boy,"	
Short Duration, . . . . .	667	and a Few Other Cases of Hysteric	
Evolution of Pulmonary Tubercu-		Simulation, . . . . .	595
losis in Lues Hereditaria Tardia,		Fundal Section in the Conservative	
Exophthalmic Goitre in Children, . .	732	Cæsarean Section, The, . . . . .	731
Experimental Contribution on the		F. W. Headland, M.D., on Homœop-	
Action of Hydrastis Canadensis		athy. Charles S. Mack, M.D., . . .	94
and of Ergotin upon the Ute-			
rus, . . . . .	137	Gallic Acid in Phthisis Pulmonalis,	
Investigations on Asepsis in Lap-		Galvanism, Exophthalmic Goitre,	
arotomy, . . . . .	729	Treatment by Means of, . . . . .	794
Extirpation of the Uterus, Tech-		Gangrenous Affections, On the Value	
nique of, . . . . .	473	of Lachesis in, . . . . .	143
Extragenital Lesions of Syphilis, . .	726	Gelatine as a Hæmostatic, . . . . .	215
Eye and Its Appendages, Syphilitic		Gelsemium Sempervirens. Edward	
Diseases of the, . . . . .	408	Cranch, Ph.S., M.D., . . . . .	117
By Cassareep, New Treatment of		The Indications for, . . . . .	270
Ulcer and Other Infectious		General Paresis. C. Spencer Kinney,	
Diseases of the, . . . . .	604	M.D., . . . . .	425
Conditions Diagnostic in General		Geographical Distribution, Propy-	
Diseases. D. A. Mac-		laxis and Therapeutics of Tetanus,	
Lachlan, M.D., . . . . .	514	The, . . . . .	72
Disease, Modern Treatment of		Glaucoma in Eyes Without Crystal-	
External. C. Gurnee Fel-		line Lens. The Occurrence of, . . .	668
lows, M.D., . . . . .	567	Glonoine in Cerebral Congestion, . .	144
Strain in Headaches, . . . . .	476	in Hæmoptysis, . . . . .	335
in Typhoid Fever, . . . . .	138	Glottis, Three Remedies in Spasm	
		of the, . . . . .	205
Face Presentations with the Chin		Glycosuria, Antimonium Tartari-	
Posterior, Treatment of, . . . . .	219	cum and, . . . . .	272
Fæcal Matter, Its Relation to Dis-		Goitre, Iodine in, . . . . .	413
eases of the Alimentary and Gen-		Lycopus in Exophthalmic, . . . . .	477
ital Tracts, and its Treatment, Ret-		Treatment by Means of Galvan-	
ained. Edward M. Deacon, M.D., . .	300	ism, Exophthalmic, . . . . .	794
Faringer, H. R., M.D. Sarcoma of		Gonorrhœa, . . . . .	771
the Uterus with Serum Treatment,		Citrate of Silver (Itrol) for, . . .	529
Fellows, C. Gurnee, M.D. Modern		Recurrent, . . . . .	665
Treatment of External Eye Dis-		Remedies for, . . . . .	141
ease, . . . . .	567	Treatment of, . . . . .	267
Ferrum Chloridum in Chronic Dif-		in Women, Residual, . . . . .	600
fuse Nephritis, . . . . .	735	Gonorrhœal Rheumatism, . . . . .	534
Phosphoricum, . . . . .	799	Gout, Atypical, . . . . .	198
Phosphoricum in Congestion of		Grip, Diseases of the Eye Depend-	
the Lungs, . . . . .	671	ent on Epidemic Influenza or, . . .	269



	PAGE		PAGE
Guernsey, Joseph C., A.M., M.D., Homœopathic Treatment of Burns and Scalds, . . . . .	98	Hemiatrophy of the Tongue, . . . .	68
Suggestions on the Bacteriology of Typhoid Fever, . . . . .	220	Hemicrania, Sanguinaria in, . . . .	416
Gumma of the Base of the Brain, A Case of, . . . . .	400	Hemolytics, Some Little Understood, .	733
Gynaecology, Local Gynæcological Treatment and the Indications for Remedies in. J. Lewis Van Tine, M.D., . . . . .	182	Hemoptysis, Glonoine in, . . . . .	335
Hæmaturia from Healthy Kidneys, .	196	Hepar Sulphur in "Colds," . . . .	670
Hæmoglobin and the Red and White Blood-Corpuscles in Pregnancy and the Puerperal Period, . . . .	190	Hepatic Abscess Due to an Appendi- citis, with Illustrations and a Series of Microscopic Slides. Charles Becker, M.D., . . . . .	421
Hæmorrhage, Drug Selection in the Treatment of Intercranial, . . . .	206	Origin, China in Ascites of, . . . .	736
After Middle Age, and its Bearing on the Duration of Life, On the Occurrence of Retinal, . . . . .	309	Heredity and the Development of Myopia, . . . . .	795
The Treatment of Atonic Uter- ine, . . . . .	603	Hereditary Spastic Paraplegia, . . .	403
Hæmorrhages in the Cerebro-Spinal Canal in the New-Born, . . . . .	56	Holocain upon Diffusion of Fluids from the Conjunctival Sac to the Anterior Chamber, The Influence of, . . . . .	668
Hæmorrhagica Cured by Adminis- tration of Iron, A Case of Neuro-Retinitis, . . . . .	475	Homœopathic Methods, . . . . .	780
Otitis Media Acuta, . . . . .	139	Treatment of Burns and Scalds. Joseph C. Guernsey, A.M., M.D., .	98
Hæmorrhoids, The Treatment of. F. Walter Briery, M.S., M.D., . . .	650	Treatment of Pneumonia in Chil- dren, The, . . . . .	608
Hæmostatic, Gelatine as a, . . . .	215	Uses of Cina. Charles Mohr, M.D., . . . . .	47
Hahnemann Medical College of Phil- adelphia, Academy of Music, May 12, 1893, an Address Delivered at the Jubilee Com- mencement of the, William Tod Helmuth, M.D., LL.D., . . .	347	Homœopathy, Its Origin, Meaning and Scope. Pemberton Dud- ley, M.D., . . . . .	545
Monument, The, . . . . .	263	Stillé and. Charles S. Mack, M.D., . . . . .	216
Hale, E. M., M.D. Tachycardia and Exophthalmos in Children, . . . .	145	How Can the Teaching of the Spe- cialties in the Undergraduate Course be Made to Serve its True and Best Purpose—the Qualifica- tion of the Student for General Practice? James C. Wood, M.D., Hubbard, Chas. H., M.D. Let Us Reason Together, . . . . .	621
Half-Pennies Impacted in the Œso- phagus for Months, . . . . .	720	Hydrastis Canadensis and of Ergo- tin upon the Uterus. Experimen- tal Contribution on the Action of, Hygiene of the Middletown State Homœopathic Hospital, The, Maurice C. Ashley, M.D., . . . .	772
Hall, P. Sharpless, B.S., M.D. Serum- Therapy. Illustrated, . . . . .	41	137	286
Hands, The Disinfection of the, . . .	408	Hypertrophy of the Lingual Tonsil, Hypospadias, A New Operation for Balanic, . . . . .	139
Hay Fever, Formaldehyde in, . . .	668	599	
The Treatment of Pseudo-, . . . .	539	Hysterectomies, The Technique in Thirty Vaginal. De Witt G. Wil- cox, M.D., . . . . .	224
Heart Disease, Bad Nauheim, Treat- ment of. Edward R. Snader, M.D., . . . . .	1	Hysteria Combined with Reflex Pa- ralysis of the Pupil, . . . . .	667
at Home, The Bad Nauheim (Schott) Treatment of. Ed- ward R. Snader, M.D., . . . . .	698	Hysterical Simulation, A "Frog-Girl," an "Angle-Worm Boy," and a few Other Cases of, . . . . .	595
Heart Diseases, Iodine in the Ana- sarca of, . . . . .	543	Hysterical Aphonia, . . . . .	538
Disturbances in Dyspepsia, . . . .	265	Origin, Pseudo-Goitre of, . . . .	412
Murmurs in Childhood, The Di- agnostic Value of, . . . . .	593	Ignatia in Emotions, . . . . .	23
and the Thyroid Gland, Nerves of the, . . . . .	67	Illumination upon Acuity of Vision and the Development of Myopia, The Influence of Proper, . . . . .	330
Helmuth, William Tod, M.D., LL.D., An Address Delivered at the Jubi- lee Commencement of the Hahne- mann Medical College of Philadel- phia, Academy of Music, May 12, 1893, . . . . .	347	Impotency, Selenium in, . . . . .	413
Helps in Circumcision. Landreth W. Thompson, M.D., . . . . .	173	Inanition, Remedies for Acute, . . .	669
		Indicanuria in Diseases of Children, Indurated Chancere of the Tonsils, .	400
		Infantile Mortality Necessary? Is the Present High Rate of. A. W. Bailey, M.D., . . . . .	197
		Infants, The Causes of Difficult De- fecation in, . . . . .	253
			406

	PAGE		PAGE
Infants, Some Thoughts on Milk as a Food for. T. E. Parker, M.D.,	238	Hæmaturia from Healthy,	196
Infection? Is Cauterization with a Hot Iron Protection Against,	474	Pathogenic Action of Kali Chloricum on the. F. H. Pritchard, M.D.,	37
Infections, The Tonsils as Gates of Entrance for Severe General,	531	Kinney, C. Spencer, M.D. General Paresis,	425
Influence of Alcoholism of the Father Upon the Vitality of the Child, of Odors on the Voice,	51 181	Kolpeurynter, The Intrauterine Use of the,	471
Inhalation in Catarrh of the Upper Air-Passages, For,	203	Kreosotum in Eczema,	271
Institute Experiences. George B. Peck, M.D.,	376	Labor, Cancer of the Neck Complicating Pregnancy and,	325
Intrauterine Use of the Kolpeurynter, The,	471	Labyrinth and Amyl Nitrite Test, Chronic Anæmia of the,	139
Iodide of Potash as a Diagnostic Measure in Pulmonary Tuberculosis,	265	Labyrinthine Phenomena Dependent Upon Middle-Ear Diseases, and Their Relief by Local Treatment,	794
of Potassium in Cataract,	330	Laceration of the Cervix,	405
Iodine in the Anasarca of Heart Diseases,	543	Lachesis in Climacteric Neurasthenia,	540
in Diseases of the Circulatory Apparatus, and Especially in Angina Pectoris,	317	In Gangrenous Affections, On the Value of,	143
in Goitre,	413	Laidlaw, George Frederick, M.D. Semmola's Views on the Pathology and Treatment of Bright's Disease,	673
in Millar's Asthma,	414	The Treatment of Pneumonia,	559
in Pneumonia. W. T. Laird, M.D.,	692	Laird, W. T., M.D. Iodine in Pneumonia,	692
in Tuberculosis Meningitis,	670	Laparotomies, Report on Six Hundred,	730
Iodum in Pneumonia,	542	Laparotomy, Contribution to the Study of Secondary,	137
Iodoform, Partial Atrophy of the Optic Nerves Following a Cutaneous Burn Treated by,	795	Experimental Investigations on Asepsis in,	729
Psychic Disturbances Appearing During Treatment with,	728	And Implantation of the Uterus Within the Abdominal Incision. Illustrated. The Correction of Inveterate Hystero-Recto-Vesico-Ptois by. T. L. Macdonald, M.D.,	279
Iron, A Case of Neuro-Retinitis Hæmorrhagica Cured by Administration of,	475	Laryngitis, Causes and Results, Chronic,	538
Irreducible Form of Uterine Ante-flexion. Illustrated. The Surgical Treatment of,	232	Larynx, Aurum Triphyllum on the, Lawrence, F. Mortimer, M.D. Treatment of Rheumatoid Arthritis,	176
Irrigation with Salt Solution in Surgical Practice,	602	Lead-Poisoning, The Anæmia of,	607
Ivy Poisoning, Treatment of,	270	Lens, The Occurrence of Glaucoma in Eyes Without Crystalline,	668
Jeffrey. George Clinton, M.D., The Bulbous Urethrotome. Illustrated, Joints, Surgery of the,	310 322	Let Us Reason Together. Charles H. Hubbard, M.D.,	772
Kali Bichromicum, The Cough of,	207	Leucæmia, Acute,	464
Chloricum on the Kidneys, Pathogenic Action of. F. H. Pritchard, M.D.,	37	Leucorrhæa, Borax in,	479
Keep Cool,	591	Local Gynæcological Treatment and the Indications for Remedies in Gynæcology. J. Lewis Van Tine, M.D.,	182
Keratitis, A Sequel of Influenza, Parenchymatous,	538	Locomotor Ataxia, Mercurius Corr. in,	80
Kerosene, A Case of Fatal Poisoning with,	533	Suspension in. Illustrated. John J. Tuller, M.D.,	360
Kidney, An Expedient to Determine Positively Whether a Communication Exists Between Fistulous Openings in the Lumbar or Hypogastric Region and the Bladder or,	200	Lues Hereditaria Tardia, Evolution of Pulmonary Tuberculosis in,	447
Early Diagnosis, Operability, Tuberculosis of the,	659	Lungs, Atropin in Œdema of the,	787
Kidneys, in the Convalescence of Typhoid Fever, The Elimination En Masse of Typhoid Bacilli, Through the,	467	Ferrum Phosphoricum in Congestion of the,	671
		Lycopus in Exophthalmic Goitre,	477
		Lyle, W. H., M.D. Phlyctenular Ophthalmia,	282

	PAGE		PAGE
Mack, Chas. S., M.D. F. W. Head-		Therapeutics of Chronic Bright's	
land, M.D., on Homœopathy.	94	Disease, . . . . .	102
Stillé and Homœopathy, . . . .	216	Therapeutics of Oxaluria, . . .	277
Macdonald, T. Lee, M.D. The Cor-		Mitral Insufficiency, Asparagin in, .	797
rection of Inveterate Hysterio-		Modern Treatment of External Eye	
Recto-Vesico-Ptosis by Laparoto-		Disease. C. Gurnee Fellows, M.D.,	567
my and Implantation of the Uterus		Mohr, Charles, M.D. Homœopathic	
Within the Abdominal Incision. .	279	Uses of Cina, . . . . .	47
MacLachlan, D. A., M.D. Eye Con-		Mortality of the Various Operations	
ditions Diagnostic in General Dis-		for Fibroid Tumors of the Uterus,	
eases, . . . . .	514	The, . . . . .	552
Maddux, D. P., M.D. Treatment of		Mucous Membranes, Alumina in Re-	
Abscess of Superficial Tissues, .	110	laxed, . . . . .	653
Malaria and the Cuban Campaign, .	465	Myasis of the Nose and Ears, . . .	533
From Microscopic Examination		Mydriatics of Short Duration, Euph-	
of the Blood, Diagnosis of, . . .	788	thalmic and, . . . . .	667
Male or Female, . . . . .	125	Myopia, Heredity and the Devel-	
Measles, Walter Sands Mills, M.D.,	246	opment of, . . . . .	795
Differential Diagnosis of Small-		Myrrh in the Mixed Infection of	
Pox and, . . . . .	320	Diphtheria, . . . . .	398
A New Diagnostic Sign of, . . .	596	Nature of Vernal Conjunctivitis, .	331
Phosphorus in, . . . . .	450	Nephritis, Ferrum Chloridum in	
Meetings of the Pennsylvania and		Chronic Diffuse, . . . . .	735
New York Societies, . . . . .	587	Following Dysentery; Uræmia;	
Medical College Education, . . .	312	Subcutaneous Injections of	
Results of the War, . . . . .	459	Salt Solution; Recovery, . . .	
Student, The Preparatory Edu-		Acute, . . . . .	787
cational Needs of the Ameri-		In a Child, A Case of Chronic	
can, Pemberton Dudley, M.D.,	337	Diffuse, Frank H. Pritchard,	
Melancholia and Neurasthenia, The		M.D., . . . . .	776
Sanitary Treatment of, Robert		Nitric Acid in Renal Lithiasis	
Walter, M.D., . . . . .	743	and Chronic Interstitial, . . .	542
Meningitis, The Medicinal Treat-		A Point in the Treatment of	
ment of, . . . . .	541	Scarlatinous, . . . . .	532
Menstruation, Senecio in Disorders		The Treatment of Scarlatinal,	
of, . . . . .	205	Charles J. V. Fries, Ph.D.,	
Mercurius Corr. in Locomotor Ataxia,	80	M.D., . . . . .	451
The Differentiation of Mezere-		Under Observation for Two	
um from, . . . . .	336	Years, and Pursuing an Ab-	
Mezereum vs., . . . . .	410	normally Favorable Course, A	
Metatarsalgia, . . . . .	405	Case of Chronic Parenchy-	
Metritis with Nervous Complica-		matous, . . . . .	467
tions, . . . . .	601	Nerves of the Heart and the Thy-	
Mezereum and Its Therapeutic		roid Gland, . . . . .	67
Sphere, . . . . .	414	Nervous Complications, Metritis	
From Mercurius, The Differen-		with, . . . . .	601
tiation of, . . . . .	336	System, Picric Acid in Diseases	
vs. Mercurius, . . . . .	410	of the, . . . . .	335
in Sore Throat, . . . . .	542	Neuralgia Facialis, Veratrum Album	
Microscopic Examination of the Con-		in, . . . . .	672
junctival Secretions from a Clin-		Neurasthenia, Anacardium, . . .	412
ical Point of View, . . . . .	725	A Few Remedies for, . . . . .	542
Military Hygiene, . . . . .	588	Lachesis in Climacteric, . . .	540
Milk, Artificial Feeding of Infants		Symptomatology of, . . . . .	197
with Synthetical, C. Sigmund		The Sanitary Treatment of Mel-	
Raue, M.D., . . . . .	384	ancholia and, Robert Walter,	
As a Food for Infants, Some		M.D., . . . . .	743
Thoughts on, T. E. Parker,		Neuron, John J. Tuller, M.D., .	209
M.D., . . . . .	238	Neuroses to Pregnancy and Parturi-	
For Infants, . . . . .	456	tion, The Relation of Some, . .	319
Mills, Walter Sands, M.D. A Clin-		New Year's Resolutions, . . . .	57
ical Lecture on Various Forms		Nitric Acid in Renal Lithiasis and	
of Stupor, Unconsciousness and		Chronic Interstitial Nephritis, .	542
Coma, with the Differential		Northrop, H. L., M.D. Punctured	
Diagnosis and Emergency		Wound of the Common Carotid	
Treatment, . . . . .	573	Artery, . . . . .	712
Measles, . . . . .	246	Norton, C. R., M.D. Treatment of	
Mitchell, Clifford, M.D. Beer and		Abortion, . . . . .	150
the Bicycle, . . . . .	439	Nose and Ears, Myasis of the, . .	533



	PAGE		PAGE
Nose, The Much Abused, . . . . .	330	of Stricture of the Male Urethra.	
Nutrition, Joseph Pettée Cobb, M.D., . . . . .	553	Carl V. Vischer, M.D., . . . . .	166
Nux Vom., Coughs of Rumex and, . . . . .	270	Peck, George B., A.M.M.D. Institute	
In Dysentery, . . . . .	510	Experiences, . . . . .	376
Obstetrics, A Few Thoughts on the		Statistics New and Old, . . . . .	743
Surgical Phase of, G. Maxwell		Pertussis and Parotiditis, Their	
Christine, M.D., . . . . .	156	Treatment, . . . . .	641
Ocular Headaches, . . . . .	139	Pelvic Diseases, Colpotomy and the	
Oedema in Fractures, . . . . .	124	Surgical Treatment of, . . . . .	268
On the Family Form of Acute,		Pen-Picture of a Patient at Bad	
Circumscribed, . . . . .	634	Nauheim — A Glimpse "Before"	
Œsophagus for Months, Half Pen-		and "After" Taking, A. Edward	
nies Impacted in the, . . . . .	720	R. Snader, M.D., . . . . .	491
Operation Justifiable for Fibroid		Perineorrhaphy, Cocaine Anæsthe-	
Tumors of the Uterus? When		sia in, . . . . .	200
is, . . . . .	323	Peritoneal Section, The After-Treat-	
In Mammary Tumors, A Plea		ment of, . . . . .	603
for Early, William B. Van		Peritonitis, O. S. Runnels, A.M.,	
Lennep, A.M., M.D., . . . . .	609	M.D., . . . . .	481
Operations, Packing of the Puerperal		And Its Surgical Treatment,	
Uterus After Intrauterine, . . . . .	537	Septic, . . . . .	789
Operative Treatment of Wandering		Pertussin, A Saccharated Extract of	
Spleen, Walter Strong, M.D., . . . . .	52	Thymic, in Whooping-Cough, . . . . .	606
Ophthalmia in New-Born Children,		Pertussis, W. A. Weaver, M.D., . . . . .	293
Treatment of Purulent, . . . . .	798	and Parotiditis, Their Treat-	
Neonatorum, Cases of, . . . . .	331	ment, George B. Peck, M.D., . . . . .	641
Potassium Permanganate in, . . . . .	272	Pharmacopœia, . . . . .	781
Otitis Media Acuta Hæmorrhagica, . . . . .	139	Phlyctenular Ophthalmia, W. H.	
Treatment of Suppurative, . . . . .	592	Lyle, M.D., . . . . .	282
Otological Dont's, A Few, . . . . .	732	Phosphorus as a Cough Remedy, . . . . .	208
Our Graduate, . . . . .	397	in Measles, . . . . .	450
Ovarian Transplantation, . . . . .	473	Phthisis Pulmonalis, Gallic Acid in, . . . . .	410
Ovaries in Retroversion and Retro-		Physician of the Argentine Republic, The Most Ancient, . . . . .	725
flexion of the Uterus, Displace-		Physiological and Pathological Pup-	
ment of the, . . . . .	323	pil, The, . . . . .	538
Oxaluria, Therapeutics of, Clifford		Picric Acid in Diseases of the Ner-	
Mitchell, M.D., . . . . .	277	vous System, . . . . .	335
Pain and Menstruation in Ectopic		Placenta, A Case of Ruptured Ute-	
Pregnancy, The, . . . . .	594	rus in Manual Extraction of the, . . . . .	666
Pains in the Right Hypochondrium, . . . . .	797	Plea for Early Operation in Mam-	
Papoid, . . . . .	661	mary Tumors, A. William B. Van	
Paralysis Occurring in the Course of		Lennep, A.M., M.D., . . . . .	609
Antirabic Treatment, Acute		Plumpness, Pulmonary Tuberculo-	
Ascending, . . . . .	131	sis with Preservation of the	
of the Pupil, Hysteria Combined		Natural, . . . . .	317
with Reflex, . . . . .	667	Pneumonia in Children, The Homœ-	
The Treatment of Post Diphthe-		opathic Treatment of, . . . . .	608
ritic, . . . . .	411	Iodine in, W. T. Laird, M.D., . . . . .	692
Paraplegia, Hereditary Spastic, . . . . .	403	Iodine in, . . . . .	542
Partial Atrophy of the Optic Nerves		Some Remedies in, . . . . .	142
Following a Cutaneous Burn		The Treatment of, George	
Treated by Iodoform, . . . . .	795	Frederick Laidlaw, M.D., . . . . .	559
Potassium Iodide in Spastic Ataxia, . . . . .	141	A Case of Thrombosis of the	
Parenchymatous Keratitis, A Sequel		Femoral Vein in Croupous, . . . . .	71
of Influenza, . . . . .	538	Poisoning by Calomel, . . . . .	129
Nephritis, Under Observation		with Kerosene, A Case of Fatal, . . . . .	533
for Two Years, and Pursuing		Potassium Iodide in Spastic Ataxic	
an Abnormally Favorable		Paraplegia, . . . . .	141
Course, A Case of Chronic, . . . . .	467	Permanganate in Ophthalmia, . . . . .	272
Parker T. E., M.D. Some Thoughts		Practical Point in the Technique of	
on Milk as a Food for Infants, . . . . .	238	Abdominal Section, A, . . . . .	408
Pathogenic Action of Kali Chlori-		Pregnancy, Appendicitis During, . . . . .	660
cum on the Kidneys, F. H. Prit-		with Eclampsia, A Case of Ex-	
chard, M.D., . . . . .	37	tra-Uterine, . . . . .	326
Pathological Changes Induced by		The Pain and Menstruation in	
Apis Mellifica, The, . . . . .	79	Ectopic, . . . . .	594
Pathology of Acromegaly, . . . . .	67	and Parturition, The Relation of	
		Some Neurosis to, . . . . .	319
		and the Puerperal Period, Hæmo-	

	PAGE		PAGE
globin and the Red and White Blood-Corpuscles in, . . .	190	Ptyalism in Consequence of Retroflexion of a Gravid Uterus, A Case of, . . . . .	202
Signification of Rupture of the Tube and of Tubal Abortion by Evolution. The Prognosis and Treatment of Tubal, . . .	597	Quinine Blindness, . . . . .	203
Signs and Symptoms of Beginning, . . . . .	328	Rachitis, Calcarea Carbonica in Scorbutic, . . . . .	797
The Toxæmia of, . . . . .	324	Random Therapeutic Hints, . . . .	605
Preparatory Educational Needs of the American Medical Student, The. Pemberton Dudley, M.D., . .	337	Raue, C. Sigmund, M.D. The Artificial Feeding of Infants with Synthetical Milk, . . . . .	384
Present High-Rate of Infantile Mortality Necessary? Is the. A. W. Baily, M.D., . . . . .	253	The Diathetic Diseases and their Influence Upon the Course and Treatment of the Acute Illnesses of Childhood, . . . . .	763
Price, Eldridge C., M.D. Some Fallacies, . . . . .	417	Rectum and Sigmoid Flexures, Diagnosis of Diseases of the Upper, . .	404
Pritchard, Frank H., M.D. A Case of Chronic Diffuse Nephritis in a Child, . . . . .	776	Refraction as a Cause of Discomfort and Disease, Slight Errors of, . . .	329
Clinical Certainties, . . . . .	636	Reichmann's Disease, . . . . .	785
Pathogenic Action of Kali Chloricum on the Kidneys, . . . .	37	Remedies for Gonorrhœa, . . . . .	141
Two Peculiar Cases of Diphtheria, . . . . .	511	Removal of a Foreign Body From the Trachea by Intubation, . . . .	203
Probabilities, . . . . .	654	Renal Lithiasis and Chronic Interstitial Nephritis, Nitric Acid in, . .	542
Professor Trier's Last Illness, . . .	785	Replacement of the Retroverted Uterus, . . . . .	201
Prostate, Remarks on the Treatment of Stone in the Bladder When Associated with Hypertrophied, . . .	469	Respiratory Affections, The Use of Aconite and of Ferrum Phos. in, . .	206
Protargol in Ophthalmic Practice, . .	476	Retinal Hæmorrhage after Middle Age, and its Bearing on the Duration of Life, On the Occurrence of, . . . . .	309
Pseudo-Goitre of Hysterical Origin, .	412	Retinitis, Diabetic, . . . . .	269
Psorinum, The Characteristics of, . . .	335	Rheumatic Arthritis, Surgical Treatment of Acute, . . . . .	199
The Bowel Symptoms of, . . . . .	335	Diathesis, The Treatment of, . . .	271
Psychic Disturbances Appearing During Treatment with Iodoform, . .	728	and Gouty Affections of the Throat, Remarks on, . . . . .	732
Psychology of the Vision of Children, The, . . . . .	409	Rheumatism, the Bacteriology of, . .	401
Ptosis by Laparotomy, and Implantation of the Uterus Within the Abdominal Incision. Illustrated. The Correction of Inveterate Hystero - Recto - Vesico. T. L. Macdonald, M.D., . . . . .	279	Gonorrhœal, . . . . .	534
as a Symptom in Abscess of the Temporal Bone, . . . . .	572	Ruta in, . . . . .	316
Puerperal Infection, The Bacteriology of, . . . . .	730	Rheumatoid Arthritis, Treatment of. F. Mortimer Lawrence, M.D., in Scarlatina, . . . . .	176 144
Eclampsia, . . . . .	601	Rhus Tox., A Comparison of Rhododendron and. William D. Young, M.D., . . . . .	769
Infection, The Treatment of, . . . .	326	A Few Characteristics of, . . . .	800
Sepsis, Treatment of, . . . . .	602	Rumex and Nux Vom., Coughs of, . .	270
Septicæmia Treated by Hypodermic Injections of Creosote, . . .	600	Runnels, O. S., A.M., M.D., Peritonitis, . . . . .	481
Pulmonary Tuberculosis, with Preservation of the Natural Plumpness, . . . . .	317	Ruta in Rheumatism, . . . . .	316
Iodide of Potash as a Diagnostic Measure in, . . . . .	265	Sacculation of the Pregnant Uterus Following Vento-Fixation, . . . .	327
Pulse, The Hard, . . . . .	399	Sage as an Antisudoral, . . . . .	320
Punctured Wound of the Common Carotid Artery. H. L. Northrop, M.D., . . . . .	712	in Nocturnal Sweats. Salvia Officialis, . . . . .	414
Pupil, The Physiological and the Pathological, . . . . .	538	Salt Solution in Surgical Practice, Irrigation with, . . . . .	602
Purpura, Two Cases of Infectious, . .	725	Sanguinaria Canadensis, the Cerebral Symptoms of, . . . . .	620
Pyelitis, The Differential Diagnosis of Cystitis and, . . . . .	660	in Hemicrania, . . . . .	416
Pyro-Septicæmia, Veratrum Viride in, . . . . .	144	Sanitary Treatment of Melancholia and Neurasthenia, The. Robert Walter, M.D., . . . . .	743
		Sarcoma of the Uterus with Serum Treatment. H. R. Faringer, M.D., .	501

	PAGE		PAGE
Scarlatina, <i>Rhus Toxicodendron</i> in,	144	Sterilizing Silk and Catgut Sutures, Improved Method for,	665
Scarlatinous Nephritis, A Point in the Treatment of,	532	Stillé and Homœopathy. Charles S. Mack, M.D.,	216
Scarlet Fever Without a Rise of Temperature,	531	Stomach, Severe Cerebral Symptoms with Great Dilatation of the,	786
Scrofulosis, Clinical Diagnosis of,	70	Unique Case of Complete Removal of the,	133
Searle, W. S., M.D. Clinical Certainties,	170	Streptococic Infection, <i>Veratrum Viride</i> for,	734
Selenium in Impotency,	413	Strong, Walter, M.D. Operative Treatment of Wandering Spleen,	52
Semi-Centennial of Hahnemann Medical College, Philadelphia,	262	Strophanthus, A Study in,	204
Semmola's Views on the Pathology and Treatment of Bright's Disease. George Frederick Laidlaw, M.D.,	673	Study of Kola, <i>Cratægus</i> and,	140
Senecio Aureus,	465	Strychnine Poisoning,	480
in Disorders of Menstruation,	205	Study of Kola, <i>Cratægus</i> and <i>Strophanthus</i> ,	140
Gracilis in Diseases of Women,	543	of <i>Lycopodium</i> and <i>Lachesis</i> , A New. A. W. Woodward, M.D.,	24
Serum—Therapy, Illustrated. P. Sharples Hall, B.S., M.D.,	41	Stupor, Unconsciousness and Coma, with the Differential Diagnosis and Emergency Treatment, A Clinical Lecture on Various Forms of. Walter Sands Mills, M.D.,	573
Treatment, Sarcoma of the Uterus with. H. R. Faringer, M.D.,	501	Sudden Death Following an Injection of Antidiphtheritic Serum for Asthma,	787
Sexual Passions, The Medical Treatment of. Johannes Arschagouni, M.D.,	440	Sunstroke an Epidemic Disease? Is,	663
Signification of Rupture of the Tube and of Tubal Abortion by Evolution; The Prognosis and Treatment of Tubal Pregnancy,	597	Suppurative Otitis Media, Treatment of,	592
Signs and Symptoms of Beginning Pregnancy,	328	Surgery of the Joints,	322
Silver Bougies for the Treatment of Catarrhal Endometritis, Soluble,	473	Surgical Aspect of the Pathology of Tuberculosis of the Bones and Joints,	199
Skiagraphy, Diagnosis of Stone in the Bladder by,	666	Dressing, Sodium Bicarbonate Solution as a. Bertrand H. Wilbur, M.D., Sitka, Alaska,	695
Small-Pox and Measles, Differential Diagnosis of,	320	Hints, 74, 135, 195, 403-405, 598,	664
Snader, Edward R., M.D. Bad Nauheim Treatment of Heart Disease,	1	Treatment of Acute Rheumatic Arthritis,	199
The Bad Nauheim (Schott) Treatment of Heart Disease at Home,	698	of Epilepsy, its Indications and Consequences,	134
A Pen Picture of a Patient at Bad Nauheim—A Glimpse "Before" and "After" Taking,	491	of the Irreducible Form of Uterine Antelexion, illustrated. B. F. Betts, M.D.,	232
Sodium Bicarbonate Solution as a Surgical Dressing. Bertrand H. Wilbur, M.D., Sitka, Alaska,	695	of Irreducible Retroflexion of the Pregnant Uterus, The,	603
Solanum Carolinense, The Therapeutic Uses of,	539	Septic Peritonitis and Its,	789
Some Fallacies. Eldridge C. Price, M.D.,	417	Suspension in Locomotor Ataxia, Illustrated. John J. Tuller, M.D.,	360
Little Understood Hemolytics, Remedies in Pneumonia,	142	Suture Materials and Methods in Celiotomy,	321
Spanish Flies, Venesection, Emetics and,	726	Sutures, Improved Method for Sterilizing Silk and Catgut,	665
Spleen, Operative Treatment of Wandering. Walter Strong, M.D.,	52	Syphilis, Chopcheene in,	78
Sprains—Their Complications and Treatment, Illustrated. Gustave A. Van Lenep, M.D.,	18	of the Nasal Passages, Late Tertiary and Hereditary,	266
and their Treatment,	124	Syphilitic Diseases of the Eye and Its Appendages,	408
Statistics New and Old. George D. Peck, A.M., M.D.,	743	Symphyseotomy in Contracted Pelves, with Diameter of 8.5 to 9.5 c.m., Comparison Between Indication of Premature Labor and,	474
Statistical Study in Epilepsy,	132	Symptomatology of Neurasthenia,	197
Sterility,	537	Tabes Dorsalis, Early Pathognomic Signs of,	401
The Surgical Treatment of,	724	Tachycardia and Exophthalmos in Children. E. M. Hale, M.D.,	145
Sterilization of Catgut by the Jefferson Method,	136		



	PAGE		PAGE
Technique of Abdominal Section, A		Treatment of Abortion. C. R. Nor-	
Practical Point in the, . . .	408	ton, M.D., . . .	150
in Thirty Vaginal Hysterec-		of Abscess of Superficial Tissues.	
tomies. DeWitt G. Wilcox,		D. P. Maddux, M.D., . . .	110
M.D., . . .	224	of Atonic Uterine Hæmorrhage,	
Telling Facts, . . .	722	The, . . .	603
Temperature, Scarlet Fever Without		of Cancer by Czerny and Tru-	
a Rise of, . . .	534	neck, . . .	202
Tetanus, The Geographical Distri-		of Female Diseases, . . .	201
bution. Prophylaxis and		of Rheumatoid Arthritis. F.	
Therapeutics of, . . .	72	Mortimer Lawrence, M.D., . .	176
from a Rare Cause, A Case of, .	660	Sprains and Their, . . .	124
Thallium for Baldness, . . .	607	Trephining for Epilepsy, A Report	
The American Institute at Omaha, .	395	of Two Cases of. Sidney F. Wil-	
Army and Navy Forever, . . .	392	cox, M.D., . . .	273
Bad Nauheim (Schott) Treat-		Tuberculosis of the Bones and Joints,	
ment of Heart Disease at		Surgical Aspect of the Pathol-	
Home. Edward R. Snader,		ogy of, . . .	199
M.D., . . .	698	in Children, Clinical Forms of	
Golden Jubilee of Old Hahne-		Pulmonary, . . .	466
mann, . . .	398	Clinical Forms of Pulmonary, .	593
Omaha Meeting, . . .	528	Diagnosis of Middle-Ear, . . .	657
Shoulder, . . .	599	Following Local Glandular Tu-	
X-Rays in War, . . .	590	berculosis, . . .	464
There is Balm in Gilead, . . .	523	of the Kidney—Early Diagno-	
is no Great and no Small, . . .	721	sis—Operability, . . .	659
is Nothing Hidden But Which		in Lues Hereditaria Tardia,	
Shall be Revealed, . . .	62	Evolution of Pulmonary, . . .	447
Therapeutic Hints, . . .	68	Tuberculosis Following Local	
Therapeutics of Chronic Bright's		Glandular, . . .	464
Disease. Clifford Mitchell,		Tuberculous Meningitis, Iodine	
M.D., . . .	102	in, . . .	670
of Chronic Cystitis, The, . . .	272	Tuller, John J., M.D. Neuron, .	209
of Tetanus, The Geographical		Suspension in Locomotor Ataxia.	
Distribution, Prophylaxis and,	72	Illustrated, . . .	360
Thompson, Landreth W., M.D.,		Tumors, A Plea for Early Operation	
Helps in Circumcision, . . .	173	in Mammary. William B.	
Thoughts on Milk as a Food for In-		Van Lennep, A.M., M.D., . . .	609
fants, Some. T. E. Parker, M.D.,	238	of the Uterus, The Mortality of	
Three Cases of Bladder Tumor. Il-		the Various Operations for Fi-	
lustrated. William B. Van Len-		broid, . . .	552
nep, A.M., M.D., . . .	683	Typhoid Bacilli, Through the Kid-	
Throat Lesions in Enteric Fever, .	149	neys, in the Convalescence of	
Mezereum in, . . .	542	Typhoid Fever, The Elimina-	
Thrombosis and Embolism of the		tion En Masse of, . . .	467
Large Blood-Vessels of the		Baptisia in, . . .	80
Abdomen, Cases of, . . .	596	Fever, The Elimination En	
of the Femoral Vein in Croup-		Masse of Typhoid Bacilli	
ous Pneumonia, A Case of, . .	71	Through the Kidneys, in the	
of the Inferior Vena Cava,		Convalescence of, . . .	467
A Case of, . . .	606	The Eye in, . . .	138
of the Inferior Vena Cava,		Suggestions on the Bacteriology	
Another Case of, . . .	659	of. Joseph C. Guernsey, A.M.,	
Thyroid Gland, Nerves of the Heart		M.D., . . .	220
and the, . . .	67	Typho-Malarial Fever, . . .	69
Tinctures, Comparative Strength of.		Ulcer and Other Infectious Diseases	
J. Wilkinson Clapp, M.D., . . .	737	of the Eye by Cassareep, New	
Tongue, Hemiatrophy of the, . .	68	Treatment of, . . .	604
Notes Upon the, . . .	402	of the Stomach, The Treatment	
Tonsil, Hypertrophy of the Lingual,	139	of, . . .	662
Tonsils as Gates of Entrance for		Undulatory Current in the Diseases	
Severe General Infections,		of Women, The, . . .	77
The, . . .	531	Unique Case of Complete Removal	
Indurated Chancre of the, . . .	197	of the Stomach, . . .	133
Toxæmia of Pregnancy, The, . .	324	Uræmia, Ammonium Carb. in, . .	411
Trachea by Intubation, Removal of		And Its Treatment. E. G.	
a Foreign Body from the, . . .	203	Cowperthwaite, M.D., . . .	437
Tracheotomy for Laryngeal Diph-		Treatment of, . . .	799
theria, After Treatment of Cases		Venesection in, . . .	321
of. J. E. Belville, M.D., . . .	448		

	PAGE		PAGE
Ureter in Relation to a Fibroid Tumor, A Rare Anomaly of the. . . . .	730	Three Cases of Bladder Tumor. Illustrated, . . . . .	683
Urethra, Pathology of Stricture of the Male. Carl V. Vischer, M.D., . . . . .	166	Van Tine, J. Lewis, M.D. Local Gynecological Treatment and the Indications for Remedies in Gynecology, . . . . .	182
Urethral Stricture, Causes and Prevention of. L. T. Ashcraft, A.M., M.D., . . . . .	120	Varicocele, . . . . .	664
Of Large Calibre, Diagnosis and Treatment of. Leon T. Ashcraft, M.D., . . . . .	305	Vena Cava, A Case of Thrombosis of the Inferior, . . . . .	606
Urethrotome, The Bulbous. Illustrated. George Clinton Jeffery, M.D., . . . . .	310	Another Case of Thrombosis of the Inferior, . . . . .	659
Urine, The Diazo-Reaction in Nursing Children's, . . . . .	469	Venesection, Emetics, and Spanish Flies, . . . . .	726
Uteri, Treatment of Retropositions of, . . . . .	329	In Uræmia, . . . . .	321
Uterine Antelexion. Illustrated. The Surgical Treatment of the Irreducible Form of. B. F. Betts, M.D., . . . . .	232	Veratrum Album and Veratrum Viride, . . . . .	796
Uterus, Colpotomy and the Total Extirpation of the, . . . . .	76	in Neuralgia Facialis, . . . . .	672
The Conservative Treatment of Chronic Inversion of the, . . . . .	472	The Intestinal Symptoms of, . . . . .	272
Displacement of the Ovaries in Retroversion and Retroflexion of the, . . . . .	323	Veratrum Viride in Pyo-Septicæmia, for Streptococci Infection, . . . . .	144
Experimental Contribution on the Action of Hydrastis Canadensis and of Ergotin upon the Fibrous Tumors of the, . . . . .	137	Vertigo, Cocculus in, . . . . .	541
Following Vento-Fixation, Saccululation of the Pregnant, . . . . .	327	Vischer, Carl V., M.D. Pathology of Stricture of the Male Urethra, . . . . .	166
After Intrauterine Operations, Packing of the Puerperal, . . . . .	537	Viscum Album, A Medico-Botanical Study of, . . . . .	605
In Manual Extraction of the Placenta, A Case of Ruptured, . . . . .	666	Vision and the Development of Myopia, The Influence of Proper Illumination Upon Acuity of, . . . . .	330
A Case of Pylalism in Consequence of Retroflexion of a Gravid, . . . . .	202	Voice, Influence of Odors on the . . . . .	181
Replacement of the Retroverted, With Serum Treatment, Sarcoma of the. H. R. Faringer, M.D., . . . . .	501	Walter, Robert, M.D. The Sanitary Treatment of Melancholia and Neurasthenia, . . . . .	743
The Surgical Treatment of Irreducible Retroflexion of the Pregnant, . . . . .	603	Weaver, W. A., M.D. Pertussis, . . . . .	293
Technique of Extirpation of the, When is Operation Justifiable for Fibroid Tumors of the, . . . . .	323	Whinna, E. G., M.D. Betanaphthol-Bismuth, An Ideal Remedy in Diarrheal Diseases, . . . . .	187
Within the Abdominal Incision. Illustrated. The Correction of Inveterate Hystero-Recto-Vesico-Ptois by Laparotomy, and Implantation of the. T. L. Macdonald, M.D., . . . . .	279	Whitlow, . . . . .	535
		Fluoric Acid in, . . . . .	669
		Whooping-Cough, Diagnosis of, . . . . .	400
		Why the Proportion of Blind in the Country is Greater than in Large Cities, . . . . .	604
		Wilbur, Bertrand H., M.D., Sitka, Alaska. Sodium Bicarbonate Solution as a Surgical Dressing, . . . . .	695
		Wilcox, Sidney F., M.D. A Report of Two Cases of Trephining for Epilepsy, . . . . .	273
		Wilcox, De Witt, G., M.D. The Technique in Thirty Vaginal Hysterectomies, . . . . .	224
		Women, Residual Gonorrhœa in, . . . . .	600
		Senerio Gracilis in Diseases of, . . . . .	543
		The Undulatory Current in the Diseases of, . . . . .	77
		Wood, James C., M.D. How Can the Teaching of the Specialties in the Undergraduate Course be Made to Serve its True and Best Purpose—the Qualification of the Student for General Practice? . . . . .	621
		Woodward, A. W., M.D. A New Study of Lycopodium and Lachesis, . . . . .	24
		Young, William D., M.D. A Comparison of Rhododendron and Rhus Tox., . . . . .	769
Vagina in Pregnancy, The Bacteriology of the, . . . . .	731		
Vaginal Cæsarean Section, . . . . .	731		
Van Lennep, Gustave A., M.D., Sprains—Their Complications and Treatment. Illustrated. . . . .	18		
Van Lennep, William B., A.M., M.D. Plea for Early Operation in Mammary Tumors, . . . . .	609		

## CONTRIBUTORS TO VOLUME XXXIII.

- Johannes Arschagouni, M.D., New York, N. Y.  
 Leon T. Ashcraft, M.D., Philadelphia, Pa.  
 Maurice C. Ashley, M.D., Middletown, N. Y.  
 Fritz C. Askenstedt, M.D., Louisville, Ky.  
 A. W. Baily, M.D., Atlantic City, N. J.  
 Clarence Bartlett, M.D., Philadelphia, Pa.  
 Weston D. Bayley, M.D., Philadelphia, Pa.  
 Charles Becker, M.D., Philadelphia, Pa.  
 J. E. Belville, M.D., Philadelphia, Pa.  
 B. F. Betts, M.D., Philadelphia, Pa.  
 William H. Bigler, M.D., Philadelphia, Pa.  
 Thomas L. Bradford, M.D., Philadelphia, Pa.  
 F. Walter Brierly, M.D., Philadelphia, Pa.  
 S. G. A. Brown, M.D., Shippensburg, Pa.  
 Woodward D. Carter, M.D., Philadelphia, Pa.  
 G. Maxwell Christine, M.D., Philadelphia, Pa.  
 J. Wilkinson Clapp, M.D., Boston, Mass.  
 Joseph Pettee Cobb, M.D., Chicago, Ill.  
 Newton M. Collins, M.D., Rochester, N. Y.  
 Walter A. Corson, M.D., Atlantic City, N. J.  
 E. G. Cowperthwait, M.D., Philadelphia, Pa.  
 Edward Cranch, M.D., Erie, Pa.  
 A. M. Cushing, M.D., Springfield, Mass.  
 Edward Magee Deacon, M.D., Birdsboro, Pa.  
 Pemberton Dudley, M.D., Philadelphia, Pa.  
 H. R. Faringer, M.D., New York, N. Y.  
 C. Gurnee Fellows, M.D., Chicago, Ill.  
 Charles J. V. Fries, Ph.D., M.D., Philadelphia, Pa.  
 Charles Gatchell, M.D., Chicago, Ill.  
 Edward M. Gramm, M.D., Philadelphia, Pa.  
 Joseph C. Guernsey, M.D., Philadelphia, Pa.  
 Edwin M. Hale, M.D., Chicago, Ill.  
 P. Sharples Hall, B. S., M.D., Philadelphia, Pa.  
 Wm. Tod Helmuth, M.D., LL.D., New York, N. Y.  
 Charles H. Hubbard, M.D., Chester, Pa.  
 W. K. Ingersoll, M.D., Philadelphia, Pa.  
 George Clinton Jeffry, M.D., Brooklyn, N. Y.  
 C. Spencer Kinney, M.D., Middletown, N. Y.  
 George Frederick Laidlaw, M.D., New York, N. Y.  
 W. T. Laird, M.D., Watertown, N. Y.  
 F. Mortimer Lawrence, M.D., Philadelphia, Pa.  
 W. H. Lyle, M.D., Philadelphia, Pa.  
 T. L. Macdonald, M.D., Washington, D. C.  
 Charles S. Mack, M.D., La Porte, Ind.  
 D. A. MacLachlan, M.D., Detroit, Mich.  
 D. P. Maddux, M.D., Chester, Pa.  
 R. S. Marshall, M.D., Pittsburg, Pa.  
 Walter Sands Mills, M.D., New York, N. Y.  
 Clifford Mitchell, M.D., Chicago, Ill.  
 Charles Mohr, M.D., Philadelphia, Pa.  
 H. L. Northrop, M.D., Philadelphia, Pa.  
 C. R. Norton, M.D., Philadelphia, Pa.  
 T. E. Parker, M.D., Woodbury, N. J.  
 George B. Peck, M.D., Providence, R. I.  
 Charles Platt, Ph.D., F.C.S., Philadelphia, Pa.  
 Eldredge C. Price, M.D., Baltimore, Md.  
 Frank H. Pritchard, M.D., Monroeville, Huron county, Ohio.  
 C. Sigmund Raue, M.D., Philadelphia, Pa.  
 O. S. Runnells, M.D., Indianapolis, Ind.  
 W. S. Searle, M.D., Brooklyn, N. Y.  
 F. J. Slough, M.D., Allentown, Pa.  
 Edward R. Suader, M.D., Philadelphia, Pa.  
 George R. Southwick, M.D., Boston, Mass.  
 William Spencer, M.D., Philadelphia, Pa.  
 Walter Strong, M.D., Philadelphia, Pa.  
 Selden H. Talcott, M.D., Ph.D., Middletown, N. Y.  
 Landreth W. Thompson, M.D., Philadelphia, Pa.  
 John J. Tuller, M.D., Philadelphia, Pa.  
 William W. Van Baun, M.D., Philadelphia, Pa.  
 G. A. Van Lennep, M.D., Philadelphia, Pa.  
 William B. Van Lennep, M.D., Philadelphia, Pa.  
 J. Lewis Van Tine, M.D., Philadelphia, Pa.  
 Carl V. Vischer, M.D., Philadelphia, Pa.  
 Robert Walter, M.D., Walter's Park, Pa.  
 H. S. Weaver, M.D., Philadelphia, Pa.  
 E. G. Whinna, M.D., Philadelphia, Pa.  
 Roland T. White, M.D., Pittsburg, Pa.  
 Bertrand K. Wilbur, M.D., Sitka, Alaska.  
 DeWitt, G. Wilcox, M.D., New York, N. Y.  
 Sidney F. Wilcox, M.D., Buffalo, N. Y.  
 James C. Wood, M.D., Cleveland, Ohio.  
 A. W. Woodward, M.D., Chicago, Ill.  
 William D. Young, M.D., Buffalo, N. Y.



## CORRESPONDENTS.

- George Abbott, Philadelphia, Pa.  
 J. Wylie Anderson, M.D., Denver, Col.  
 Alfred W. Baily, M.D., Atlantic City, N. J.  
 Alonzo M. Barnes, M.D., Philadelphia, Pa.  
 Weston D. Bayley, M.D., Philadelphia, Pa.  
 J. H. Bennett, M.D., Pawtucket, R. I.  
 M. M. Bose, M.D., Calcutta, India.  
 T. L. Bradford, M.D., Philadelphia, Pa.  
 R. B. Carter, M.D., Akron, Ohio.  
 Woodward D. Carter, M.D., Philadelphia, Pa.  
 G. M. Christine, M.D., Philadelphia, Pa.  
 Allison Clokey, M.D., Louisville, Ky.  
 J. H. Closson, M.D., Philadelphia, Pa.  
 Walter A. Corson, M.D., Atlantic City, N. J.  
 Isaac Crowther, M.D., Chester, Pa.  
 A. M. Cushing, M.D., Springfield, Mass.  
 J. Roberson Day, M.D., London, England.  
 W. A. Dewey, M.D., Ann Arbor, Mich.  
 Pemberton Dudley, M.D., Philadelphia, Pa.  
 T. C. Duncan, M.D., Philadelphia, Pa.  
 John R. Fleming, M.D., Atlantic City, N. J.  
 D. A. Foote, M.D., Omaha, Neb.  
 John B. Garrison, M.D., New York, N. Y.  
 Charles Gatchell, M.D., Chicago, Ill.  
 Edward M. Gramm, M.D., Philadelphia, Pa.  
 Joseph C. Guernsey, M.D., Philadelphia, Pa.  
 J. Richey Horner, M.D., Cleveland, O.  
 E. M. Howard, M.D., Camden, N. J.  
 William H. Keim, M.D., Philadelphia, Pa.  
 Horace G. Keith, M.D., Yonkers, N. Y.  
 Wm. R. King, M.D., Washington, D. C.  
 Charles S. Mack, M.D., Laporte, Ind.  
 D. A. MacLachlan, M.D., Detroit, Mich.  
 J. H. McClelland, M.D., Pittsburg, Pa.  
 Geo. W. McDowell, M.D., New York, N. Y.  
 Edward W. Mercer, M.D., Philadelphia, Pa.  
 John L. Moffat, M.D., Brooklyn, N. Y.  
 Charles Mohr, M.D., Philadelphia, Pa.  
 George B. Moreland, M.D., Pittsburg, Pa.  
 H. L. Northrop, M.D., Philadelphia, Pa.  
 A. B. Norton, M.D., New York, N. Y.  
 N. Emmons Paine, M.D., West Newton, Mass.  
 George B. Peck, M.D., Providence, R. I.  
 Hugh Pitcairn, M.D., Hamburg, Germany.  
 Charles Platt, Ph.D., Philadelphia, Pa.  
 Eugene H. Porter, M.D., New York, N. Y.  
 F. H. Pritchard, M.D., Monroeville, Huron Co., Ohio.  
 L. Willard Reading, M.D., Philadelphia, Pa.  
 John L. Redman, M.D., Atlantic City, N. J.  
 Charles E. Richardson, M.D., Boston, Mass.  
 W. S. Searle, M.D., Brooklyn, N. Y.  
 Nathan Smilie, M.D., Philadelphia, Pa.  
 Henry M. Smith, M.D., New York, N. Y.  
 L. D. Swormstedt, M.D., Washington, D. C.  
 I. T. Talbot, M.D., Boston, Mass.  
 Frederick F. Teal, M.D., Omaha, Neb.  
 Charles H. Thomas, M.D., Cambridge, Mass.  
 Wm. W. Van Baun, M.D., Philadelphia, Pa.  
 Horace B. Ware, M.D., Scranton, Pa.  
 H. W. Westover, M.D., St. Joseph, Mo.  
 C. S. Winters, M.D., Binghamton, N. Y.  
 Edwin H. Wolcott, M.D., Rochester, Pa.  
 O. S. Wood, M.D., Omaha, Neb.  
 A. R. Wright, M.D., Buffalo, N. Y.



















